

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05653

Within corporate limits

• 5658

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. VA. b. COUNTY 85X-3 ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN b 17 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIEDMONT	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 15 ASHFIELD ST.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LEVINA Middle ELIZABETH Last ADAMS		4. DATE OF DEATH Month JUNE Day 7 Year 1956					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 21, 1881	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME D. W. ADAMS				14. MOTHER'S MAIDEN NAME CORNELIS HUFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. None		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus Parkinson's disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-20, 1955 to 6-7-1956 , that I last saw the deceased alive on 6-6-1956 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 6/7/56			
PHYSICIAN'S NAME (Type) W.F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-10-56		22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE E.S. Boal				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 6-10-56	
				24b. REGISTRAR'S SIGNATURE W.R. Franky, MD			

BUREAU A. S.

1956 1 1

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD. VAN ORMER

DR. VAN ORMER

Within corporate limits

35859

CERTIFICATE OF DEATH

05654

Reg. Dist. No. 4

1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE WEST VIRGINIA b. COUNTY MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY
d. STREET ADDRESS R.F.D.#1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ALICE Middle MARIE Last AMAN
4. DATE OF DEATH Month JUNE Day 11 Year 1956
5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH JUNE 16, 1889 9. AGE (In years last birthday) 66 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME JACOB STEIN 14. MOTHER'S MAIDEN NAME VICTORIA BRANT
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT EDWARD AMAN R. D. # 1 Ridgeley, W. Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7 Terminal Cordial Failure
DUE TO (b) Rheumatic Heart Disease, Valvular, mitral, stenosis?
DUE TO (c) Aortic ulcer, thrombosis, with embolus 2 weeks.
INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While ☐ Not while ☐ at work ☐ of work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9 June, 1956, to 11 June, 1956, that I last saw the deceased alive on 11 June, 1956, and that death occurred at 6:20 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE W. A. Van Ormer M.D. 13 June 56
PHYSICIAN'S NAME (Type) W. A. VAN ORMER Cumberland, Md.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF June 14, 1956 22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery 22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, ADDRESS Cumberland, Md. 24a. REC'D BY REGISTRAR DATE 6-14-56 24b. REGISTRAR'S SIGNATURE W. R. Dronty

WEST VIRGINIA CERTIFICATE OF DEATH

BUREAU V. 2

JUN 13 1956

RECEIVED

05655

5560

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN CumberlandLENGTH OF STAY
(in this place)
DAOHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

DOA Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN CumberlandSTREET
ADDRESS

739 Maryland Avenue

3. NAME OF
DECEASED
(Type or Print)

(First)

RANFORD

(Middle)

HENRY

(Last)

AMBROSE

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

June 20 19 56

5. SEX

Male

6. COLOR OR
RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Married

8. DATE OF BIRTH

Sept. 10, 1889

9. AGE last birthday

66

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Ret. Lineman

10b. KIND OF BUSINESS
OR INDUSTRY

Potomac-Edison

11. BIRTHPLACE (State or foreign country)

Great Cacapon, West Va. USA

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

AARON

AMBROSE

14. MOTHER'S MAIDEN NAME

ETTA

STINEBAUGH

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.)
Yes(If Yes, give war or dates of service)
WW I

16. SOCIAL SECURITY NO.

214-10-5331

17. INFORMANT & ADDRESS

739 Maryland Avenue
Mrs. Rhoda Ambrose, Cumberland, Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

526X IMMEDIATE CAUSE

(A)

Pulmonary Hemorrhage

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(B)

(C)

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

Myocardial Degeneration

INTERVAL BETWEEN
ONSET AND DEATH

10 minutes

15 yrs

5 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

M.

21e. INJURY OCCURRED
While ☐ Not while ☐
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/7/51, 19....., to 6/22/56, 19....., that I last saw the deceased

alive on 6/22/56, 19....., and that death occurred at 1:30 P.M. from the causes and on the date stated above.

SIGNATURE

122 S. Centre St. (Street, city, town, state)

DATE SIGNED

M.D.

Cumberland, Maryland

6/22/56

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

6/23/56

NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

LOCATION (City, town, or county)

Cumberland, Maryland

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

June 23, 1956

Winter R. Hunt, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

John J. Hafer, Cumberland, Maryland

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

3880

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 36

A. USUAL RESIDENCE AND HOSPITAL ADDRESS

PLACE OF DEATH

DECEASED

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

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CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

BUREAU V. 5

JUN 28 1956

RECEIVED

PHOTOGRAPH

PHOTOGRAPH OF DECEASED TO BE PLACED IN THE DEPARTMENT OF HEALTH-BALTIMORE 36

PHOTOGRAPH OF DECEASED TO BE PLACED IN THE DEPARTMENT OF HEALTH-BALTIMORE 36

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

DR. W. F. WILLIAMS MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits **5861**

CERTIFICATE OF DEATH

05656

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS WESTERNPORT	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle BECKMAN Last BECKMAN		4. DATE OF DEATH Month JUNE Day 10 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 13, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 10 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME AARON PRITTS		14. MOTHER'S MAIDEN NAME JENNIS PYLES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Since 1948	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-12-56 to 6-10-56 that I last saw the deceased alive on 6-10-56 , and that death occurred at 11:06 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) W. F. Williams Cumberland Md DATE SIGNED 6-11-56	
ACTUAL SIGNATURE W. F. Williams		PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS	
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-13-56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY North Glade Cemetery		22d. LOCATION (City, town, or county) (State) Swanton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Fiedler ADDRESS Piedmont W. Va		24a. REC'D BY REGISTRAR DATE 6-12-56	
24b. REGISTRAR'S SIGNATURE W. R. Franky, M.D.			

CERTIFICATE OF DEATH

NAME OF DECEASED ALFRED J. BROWN		AGE 45		SEX MALE		RACE WHITE		DATE OF BIRTH JAN 15 1913		PLACE OF BIRTH NEW YORK	
OCCUPATION LABORER		EDUCATION HIGH SCHOOL		MARRIAGE MARRIED		RELIGION METHODIST		DATE OF MARRIAGE JUN 10 1935		PLACE OF MARRIAGE NEW YORK	
DECEASED AT HOSPITAL		DATE OF DEATH JUL 10 1956		TIME OF DEATH 11:00 AM		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF DEATH NEW YORK	
SIGNATURE OF PHYSICIAN J. B. SMITH		SIGNATURE OF REGISTRAR J. B. SMITH		SIGNATURE OF WITNESS J. B. SMITH		SIGNATURE OF WITNESS J. B. SMITH		SIGNATURE OF WITNESS J. B. SMITH		SIGNATURE OF WITNESS J. B. SMITH	

BUREAU V. B.

JUL 14 1956

RECEIVED

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, affixing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05657

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 Cumberland		c. LENGTH OF STAY IN lb 13 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 107 Columbia	
3. NAME OF DECEASED (Type or print) First Enos Middle Earl Last Bennett		4. DATE OF DEATH Month June Day 1 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7-1911
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 4 Days 5	IF UNDER 24 HRS. Hours 1 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver for the		10b. KIND OF BUSINESS OR INDUSTRY Cumberland Transit	
11. BIRTHPLACE (State or foreign country) Artimas, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bruce P. Bennett		14. MOTHER'S MAIDEN NAME Agnes Cora Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-7850	
17. INFORMANT Memorial Hospital records, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombous about 1 hr. DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 1-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 4, 1956	
22c. NAME OF CEMETERY OR CREMATORY Fourview-Union Cemetery		22d. LOCATION (City, town, or county) (State) Artimas, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hales		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR 6/4/56		DATE June 1-1956	
24b. REGISTRAR'S SIGNATURE Walter R. Dwyer		M.D.	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
OCCASION OF DEATH _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____	
PRINTED NAME OF MEDICAL EXAMINER _____		PRINTED NAME OF DECEASED _____		PRINTED NAME OF WITNESS _____	
ADDRESS OF MEDICAL EXAMINER _____		ADDRESS OF DECEASED _____		ADDRESS OF WITNESS _____	
CITY OF MEDICAL EXAMINER _____		CITY OF DECEASED _____		CITY OF WITNESS _____	
STATE OF MEDICAL EXAMINER _____		STATE OF DECEASED _____		STATE OF WITNESS _____	
COUNTY OF MEDICAL EXAMINER _____		COUNTY OF DECEASED _____		COUNTY OF WITNESS _____	
TOWN OF MEDICAL EXAMINER _____		TOWN OF DECEASED _____		TOWN OF WITNESS _____	
ZIP CODE OF MEDICAL EXAMINER _____		ZIP CODE OF DECEASED _____		ZIP CODE OF WITNESS _____	

BUREAU V. 31

JUN 9 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05658

Reg. Dist. No.

10

5717

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage		c. LENGTH OF STAY IN 1b 63 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural) Mt. Savage			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calla Hill, on seat of truck.				d. STREET ADDRESS R.F.D. #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Bennett				4. DATE OF DEATH Month June Day 19 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21-1892	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63	IF UNDER 24 HRS. Days 63 Hours 63 Min. 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Bennett				14. MOTHER'S MAIDEN NAME Mazie Perdew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 2 16-05-6024		17. INFORMANT Address (brother) Henry Bennett, Mt. Savage, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis DUE TO (c) ?						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 19-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6 -22- 56		22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Montesant		ADDRESS HAFFER FUNERAL HOME 23 E. MAIN, FROSTBURG, MD.		24a. REC'D BY REGISTRAR 6-20-1956		24b. REGISTRAR'S SIGNATURE Veronica M. Demmitt	

STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 11

JUN 25 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05659

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural) Spring Gap</u>		c. LENGTH OF STAY IN lb <u>5 Yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Rural) Spring Gap</u>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>A.</u> Last <u>Boyd</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>19 56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26-1863</u>
9. AGE (in years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Miller</u>		14. MOTHER'S MAIDEN NAME <u>Anna Fritzmiere</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>son) Ralph Boyd, Spring Gap, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Gradual</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>June 7-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/9/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>6-9-56</u>		24b. REGISTRAR'S SIGNATURE <u>WR Drantz M.D.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 81

JUN 11 1956

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05660

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>32 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
f. STREET ADDRESS <u>719 N. Mechanic St.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Phyllis</u> Last <u>Brode</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13-1924</u>
9. AGE (In years last birthday) <u>32 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marking Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rosenbaum Bros.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis E. Brode</u>		14. MOTHER'S MAIDEN NAME <u>Helen A. Nee Brode</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-22-7112</u>	
17. INFORMANT <u>Sacred Heart Hospital records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pyogenic streptococci infection</u> DUE TO (c) <u>Criminal abortion</u> INTERVAL BETWEEN ONSET AND DEATH <u>several days</u> <u>about 15 days.</u> <u>15 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Criminal abortion</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Criminal abortion</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>May 31 19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>New York</u>		20f. (City or town) (County) (State) <u>N.Y.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 15-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 17, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sts Peter & Paul Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafey</u>		ADDRESS <u>Cumberland, Maryland</u>	
24a. REC'D BY REGISTRAR <u>June 16, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Place of death		6. Cause of death	
7. Nature of disease		8. Duration of disease		9. Date of admission to hospital	
10. Name of attending physician		11. Name of hospital		12. Name of funeral home	
13. Name of informant		14. Address of informant		15. Signature of informant	
16. Signature of Federal Examiner		17. Date of examination		18. Place of examination	

RECEIVED JUN 19 1956

BUREAU V. 1

JUN 19 1956

RECEIVED

TO HOSPITAL OR A DEDICATED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits **5664**

CERTIFICATE OF DEATH

05661

Reg. Dist. No. **4**

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. Va. b. COUNTY Mineral ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Piedmont, 85x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 761 Payette St.,				d. STREET ADDRESS West Harrison St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARTHA Middle SHAW Last CHESHIRE		4. DATE OF DEATH Month June Day 8, Year 19 56		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown 1879		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Dawson, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Simeon Clark				14. MOTHER'S MAIDEN NAME Eliza Dayton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Stella Nealis Piedmont, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Semibity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) 1 yr. 10 yrs.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 26 , 19 56 , to June 28 , 19 56 , that I last saw the deceased alive on June 7 , 19 56 , and that death occurred at 5:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard W. Trevaskas Jr. M.D.				ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/56		22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Harold Fredlock ADDRESS Piedmont, W. Va.				24a. REC'D BY REGISTRAR DATE 6-10-56		24b. REGISTRAR'S SIGNATURE W.R. Drouty, MD	

CERTIFICATE OF DEATH

DATE OF DEATH

DECEASED

AGE

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF CHILD

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BUREAU V. 1

JUN 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05662					
Within corporate limits										5665					
DR. SIMONS										Reg. Dist. No. 4					
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY ALLEGANY					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY			
c. LENGTH OF STAY IN 1b 2HRS.5 MINS.					d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First OLIVE Middle LUELLA Last COLE					4. DATE OF DEATH Month JUNE Day 4 Year 19 56										
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 17, 1869		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME GEORGE FREELAND						14. MOTHER'S MAIDEN NAME MARGARET SHAFFER									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none				17. INFORMANT MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVES.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from May 20, 1956 to June 4, 1956 , that I last saw the deceased alive on June 4, 1956 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 129 Union St., Cumberland, Md. DATE SIGNED 6/5/56															
ACTUAL SIGNATURE George M. Simon				M.D. 129 Union St., Cumberland, Md.											
PHYSICIAN'S NAME (Type)															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF June 7, 1956		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pk.				22d. LOCATION (City, town, or county) Cumberland, Md. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.						ADDRESS		24a. REC'D BY REGISTRAR DATE 6-6-56		24b. REGISTRAR'S SIGNATURE H. R. Drentz, Md.					

CERTIFICATE OF DEATH

DR. BROWN

ALLSOUTH

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JUN 7 1956

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
5566 CERTIFICATE OF DEATH									
DR. R. J. WMS Within corporate limits Reg. Dist. No. 7									
1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					d. STREET ADDRESS UNION GROVE RT. #2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SOPHIA Middle Last CRUPPER					4. DATE OF DEATH Month JUNE Day 12 Year 1956				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 30 1870		9. AGE (In years and birthday) yrs. 85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE DREYER W. CRUPPER					14. MOTHER'S MAIDEN NAME ELIZABETH KAISER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL-MEMORIAL AVE & WARWICK AVE.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Wrenia - Chr. Nephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) 5 yrs -								INTERVAL BETWEEN ONSET AND DEATH 72 hrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/7/51 , 19 51 , to 6/12/56 , 19 56 , that I last saw the deceased alive on 6/12/56 , 19 56 , and that death occurred at 8:55 P. M, from the causes and on the date stated above.									
ACTUAL SIGNATURE R. J. Williams M.D.					ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 6/12/56				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/56		22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cem.			22d. LOCATION (City, town, or county) (State) Cumberland Md		
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox ADDRESS Cumberland, Md.					24a. REC'D BY REGISTRAR 6-15-56		24b. REGISTRAR'S SIGNATURE W R Drury md		

CERTIFICATE OF DEATH

1. NAME OF DECEASED ELIZABETH KILLEN		2. SEX F		3. AGE 38	
4. RACE WHITE		5. DATE OF DEATH JUNE 28 1956		6. TIME OF DEATH 10:00 AM	
7. PLACE OF DEATH HOSPITAL		8. CITY BALTIMORE		9. COUNTY BALTIMORE	
10. STATE MARYLAND		11. ZIP CODE 21201		12. MANNER OF DEATH NATURAL	
13. CAUSE OF DEATH CORONARY HEART DISEASE		14. IMMEDIATE CAUSE MYOCARDIAL INFARCTION		15. UNDERLYING CAUSE CORONARY ARTERIOSCLEROSIS	
16. SIGNATURE OF PHYSICIAN J. H. SMITH		17. SIGNATURE OF REGISTRAR J. H. SMITH		18. SIGNATURE OF WITNESS J. H. SMITH	
19. SIGNATURE OF DECEASED ELIZABETH KILLEN		20. SIGNATURE OF NEXT OF KIN J. H. SMITH		21. SIGNATURE OF BURIAL OFFICIAL J. H. SMITH	
22. SIGNATURE OF FUNERAL HOME J. H. SMITH		23. SIGNATURE OF CHURCH J. H. SMITH		24. SIGNATURE OF CEMETERY J. H. SMITH	
25. SIGNATURE OF OTHER J. H. SMITH		26. SIGNATURE OF OTHER J. H. SMITH		27. SIGNATURE OF OTHER J. H. SMITH	
28. SIGNATURE OF OTHER J. H. SMITH		29. SIGNATURE OF OTHER J. H. SMITH		30. SIGNATURE OF OTHER J. H. SMITH	
31. SIGNATURE OF OTHER J. H. SMITH		32. SIGNATURE OF OTHER J. H. SMITH		33. SIGNATURE OF OTHER J. H. SMITH	
34. SIGNATURE OF OTHER J. H. SMITH		35. SIGNATURE OF OTHER J. H. SMITH		36. SIGNATURE OF OTHER J. H. SMITH	
37. SIGNATURE OF OTHER J. H. SMITH		38. SIGNATURE OF OTHER J. H. SMITH		39. SIGNATURE OF OTHER J. H. SMITH	
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43. SIGNATURE OF OTHER J. H. SMITH		44. SIGNATURE OF OTHER J. H. SMITH		45. SIGNATURE OF OTHER J. H. SMITH	
46. SIGNATURE OF OTHER J. H. SMITH		47. SIGNATURE OF OTHER J. H. SMITH		48. SIGNATURE OF OTHER J. H. SMITH	
49. SIGNATURE OF OTHER J. H. SMITH		50. SIGNATURE OF OTHER J. H. SMITH		51. SIGNATURE OF OTHER J. H. SMITH	
52. SIGNATURE OF OTHER J. H. SMITH		53. SIGNATURE OF OTHER J. H. SMITH		54. SIGNATURE OF OTHER J. H. SMITH	
55. SIGNATURE OF OTHER J. H. SMITH		56. SIGNATURE OF OTHER J. H. SMITH		57. SIGNATURE OF OTHER J. H. SMITH	
58. SIGNATURE OF OTHER J. H. SMITH		59. SIGNATURE OF OTHER J. H. SMITH		60. SIGNATURE OF OTHER J. H. SMITH	
61. SIGNATURE OF OTHER J. H. SMITH		62. SIGNATURE OF OTHER J. H. SMITH		63. SIGNATURE OF OTHER J. H. SMITH	
64. SIGNATURE OF OTHER J. H. SMITH		65. SIGNATURE OF OTHER J. H. SMITH		66. SIGNATURE OF OTHER J. H. SMITH	
67. SIGNATURE OF OTHER J. H. SMITH		68. SIGNATURE OF OTHER J. H. SMITH		69. SIGNATURE OF OTHER J. H. SMITH	
70. SIGNATURE OF OTHER J. H. SMITH		71. SIGNATURE OF OTHER J. H. SMITH		72. SIGNATURE OF OTHER J. H. SMITH	
73. SIGNATURE OF OTHER J. H. SMITH		74. SIGNATURE OF OTHER J. H. SMITH		75. SIGNATURE OF OTHER J. H. SMITH	
76. SIGNATURE OF OTHER J. H. SMITH		77. SIGNATURE OF OTHER J. H. SMITH		78. SIGNATURE OF OTHER J. H. SMITH	
79. SIGNATURE OF OTHER J. H. SMITH		80. SIGNATURE OF OTHER J. H. SMITH		81. SIGNATURE OF OTHER J. H. SMITH	
82. SIGNATURE OF OTHER J. H. SMITH		83. SIGNATURE OF OTHER J. H. SMITH		84. SIGNATURE OF OTHER J. H. SMITH	
85. SIGNATURE OF OTHER J. H. SMITH		86. SIGNATURE OF OTHER J. H. SMITH		87. SIGNATURE OF OTHER J. H. SMITH	
88. SIGNATURE OF OTHER J. H. SMITH		89. SIGNATURE OF OTHER J. H. SMITH		90. SIGNATURE OF OTHER J. H. SMITH	
91. SIGNATURE OF OTHER J. H. SMITH		92. SIGNATURE OF OTHER J. H. SMITH		93. SIGNATURE OF OTHER J. H. SMITH	
94. SIGNATURE OF OTHER J. H. SMITH		95. SIGNATURE OF OTHER J. H. SMITH		96. SIGNATURE OF OTHER J. H. SMITH	
97. SIGNATURE OF OTHER J. H. SMITH		98. SIGNATURE OF OTHER J. H. SMITH		99. SIGNATURE OF OTHER J. H. SMITH	
100. SIGNATURE OF OTHER J. H. SMITH		101. SIGNATURE OF OTHER J. H. SMITH		102. SIGNATURE OF OTHER J. H. SMITH	

BUREAU V. 3

JUN 28 1956

RECEIVED

5667

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Cumberland			
c. LENGTH OF STAY IN 1b 2 months				d. STREET ADDRESS Bowmans Addition, R.F.D. #3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Arthur Earl Dodrill				4. DATE OF DEATH June 15 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sep. 26, 1898	
9. AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired B.&O. Conductor - Railroad		10b. KIND OF BUSINESS OR INDUSTRY West Virginia		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Dodrill				14. MOTHER'S MAIDEN NAME Mary Ellen Burns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-12-499		17. INFORMANT Mrs. James C. Turnbull Address 115 Frederick St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial Deterioration 159X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) carcinomatous Intestined Tract. 3yrs. DUE TO (c) Chronic nephritis.				INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 7th 1956 to June 15 1956 , that I last saw the deceased alive on June 14th 1956 , and that death occurred at 4:30 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. McLean M.D.				ADDRESS (Street, city or town, state) 49 Greene St.		DATE SIGNED 6-16-56	
PHYSICIAN'S NAME (Type) James E. McLean							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 18 1956		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm H. Right ADDRESS Cumberland, Md.				24. REC'D BY REGISTRAR June 18, 1956		24b. REGISTRAR'S SIGNATURE W.R. Trant, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

JUN 19 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05665

5719 CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Lonaconing		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing			
HOSPITAL OR INSTITUTION OR STREET ADDRESS East Main Street				STREET ADDRESS East Main Street			
3. NAME OF DECEASED (Type or Print) Jennie Evans Dunn				4. DATE OF DEATH (Month) (Day) (Year) 6/15/1956			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH 4/4/1879	
9. AGE last birthday 79 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Barton, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David Evans		14. MOTHER'S MAIDEN NAME Martha Susan Warnick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Miss Gail Dunn (Daughter)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION Lonaconing, MD.		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Coronary Occlusion				ANTECEDENT CAUSE(S) DUE TO (B) Coronary Occlusion		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July, 1952, to June, 1956, that I last saw the deceased alive on June 10, 1956, and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
SIGNATURE <i>George Eichhorn</i>				ADDRESS (Street, city, town, state) <i>51 Main Lonaconing, Md</i>		DATE SIGNED <i>6/15/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/17/1956		NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		LOCATION (City, town, or county) (State) Lonaconing, MD.	
24. REC'D BY REGISTRAR DATE 6-16-56		REGISTRAR'S SIGNATURE <i>Jannette M Boal</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>George Eichhorn, Lonaconing, MD.</i>			

BUREAU V. S.

3561 61 NOV

RECEIVED

• ON THE OTHER HAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
5668 CERTIFICATE OF DEATH									
Reg. Dist. No. 4									
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 7 DAYS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.					d. STREET ADDRESS 6 EAST FIRST STREET.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First BESSIE Middle M Last DYCHE					4. DATE OF DEATH Month JUNE Day 25 Year 19 56				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 10, 1877		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) PENNA., Bard.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME THOMAS George Whorrell					14. MOTHER'S MAIDEN NAME Bessie E. Gaster				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Bernard Kuhlman, Cumberland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) 5 yrs									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12 days									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 15, 1956 , to June 25, 1956 , that I last saw the deceased alive on June 25, 1956 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE Clay E. Durrett M.D.					ADDRESS (Street, city or town, state) Cumberland and Md 92056				
DATE SIGNED June 28, 1956									
PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-28-56		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.					24. REC'D BY REGISTRAR June 28, 1956		24b. REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.		

BUREAU V. 3

JUN 29 1956

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME		LAST		FIRST		MIDDLE	
JAMES		HAMILTON		JAMES		HAMILTON	
DATE OF BIRTH		SEX		RACE		RELIGION	
JAN 1 1901		M		W		C	
PLACE OF BIRTH		COUNTRY		STATE		COUNTY	
BALTIMORE		MD		MD		BALTIMORE	
DATE OF DEATH		PLACE OF DEATH		COUNTRY		STATE	
JUN 29 1956		BALTIMORE		MD		MD	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL	
DATE OF INTERVIEW		NAME OF INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
JUN 29 1956		JAMES HAMILTON		JAMES HAMILTON		JAMES HAMILTON	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05667

DR. R. J. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORRIGANVILLE			
c. LENGTH OF STAY IN 1b 5 DAYS				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALONZO Middle C. Last FLEEGL				4. DATE OF DEATH Month JUNE Day 27 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 22, 1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED HOSTLER				10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME VALENTINE FLEEGL				14. MOTHER'S MAIDEN NAME MARY K. BURKETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 705-09-9930		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung (bronchogenic) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 162X DUE TO (c) 3 months				INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumbersland, Md.				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from 2/28/54 , 19____, to 6/27/56 , 19____, that I last saw the deceased alive on 6/26/56 , 19____, and that death occurred at 3:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. J. Williams				DATE SIGNED 6/27/56			
PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-30-56		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Cumbersland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Lepler				ADDRESS Hyndman		24a. REC'D BY REGISTRAR DATE June 29, 1956	
				24b. REGISTRAR'S SIGNATURE W. F. Franz		M. D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

DR. J. J. WILLIAMS

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BUREAU V. S.

JUL 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05668

5707

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Consolidation village		d. STREET ADDRESS Consolidation	
3. NAME OF DECEASED (Type or print) First EDWARD Middle R. Last FOLK		4. DATE OF DEATH Month June Day 25 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-1882
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stone mason-retired		10b. KIND OF BUSINESS OR INDUSTRY Smith Contract. Co. Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Folk		14. MOTHER'S MAIDEN NAME Elizabeth Eisel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-10-1115	
17. INFORMANT Mrs. Fannie Lewis, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 15 YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. X 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 13, 1956 , to JUNE 25, 1956 , that I last saw the deceased alive on JUNE 25, 1956 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin M. Rothstein		M.D. 48 BROADWAY - FROSTBURG - MD. 6/26/56	
PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-27-1956	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE 6-27-56		24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits
3670

CERTIFICATE OF DEATH

05669

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS 402 Beall St.	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle RALPH Last FRICKEY		4. DATE OF DEATH Month June Day 8 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 25, 1887
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Railway Express Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John C. Frickey		14. MOTHER'S MAIDEN NAME Pearl Korn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Wm. Frickey, 402 Beall St. Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-25 , 19 56 to 6-8 , 19 56 , that I last saw the deceased alive on 6-8 , 19 56 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. F. Williams		ADDRESS (Street, city or town, state) Cumberland, Md.	
PHYSICIAN'S NAME (Type) W. F. WILLIAMS		DATE SIGNED Wed 6/19/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 11, 1956	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE 6-11-56		24b. REGISTRAR'S SIGNATURE W. R. Frantz, Md.	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. FAW

Dr. Faw
Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist.

05670

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA. b. COUNTY FORT ASHBY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First ROGER Middle ALLEN Last GETZ		4. DATE OF DEATH Month JUNE Day 8 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 1 1949
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES O. GETZ		14. MOTHER'S MAIDEN NAME ETHEL M. RIGGLEMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephritis - with uremia 593X DUE TO Cause undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6, 1956, to June 8, 1956, that I last saw the deceased alive on June 8, 1956, and that death occurred at 10:50 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE C. W. Faw		M.D. C. W. Faw June 10	
PHYSICIAN'S NAME (Type) DR. W. FAW			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 12-56	22c. NAME OF CEMETERY OR CREMATORY Laymansville Cemetery	22d. LOCATION (City, town, or county) (State) Lamymansville, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE James E. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 6-12-56	
		24b. REGISTRAR'S SIGNATURE W. C. Dranty M.D.	

BUREAU A. S.

JUN 14 1956

RECEIVED

Outside of City Limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05671

5720

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.T.D. #3, Oldtown Road, Cumberland</u>		d. STREET ADDRESS <u>Oldtown Road, Cumberland</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Valentine Giles</u>		4. DATE OF DEATH Month Day Year <u>June 19 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Yard Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Paw Paw, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mark Giles</u>		14. MOTHER'S MAIDEN NAME <u>Emma World</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-09-3665</u>	
17. INFORMANT <u>Mrs. Joseph Ruppenkamp, Cumberland, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Nephritis & Uremia</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Changes of age</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>79</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/25/54</u> , 19 <u>54</u> , to <u>6/19/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/12/56</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>W. L. Frantz, M.D.</u> ACTUAL SIGNATURE <u>W. L. Frantz</u> M.D. PHYSICIAN'S NAME (Type) <u>W. L. Frantz</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-22-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Indian Mound</u>		22d. LOCATION (City, town, or county) (State) <u>Romey, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>June 21, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>W. L. Frantz, M.D.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 3

JUN 22 1956

RECEIVED

5672

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allerany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 26 minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 429 N. Centre Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Lysle Last Grimshaw				4. DATE OF DEATH Month 6 Day 26 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1929		9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months 26 Days 26 Hours 19 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Apprentice		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.S.A.	
13. FATHER'S NAME Cecil S. Grimshaw				14. MOTHER'S MAIDEN NAME Marie B. Barrett			
15. WAS DECEASED SEVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, ✓		16. SOCIAL SECURITY NO. 1951-1952		17. INFORMANT Address Mrs. Rosemary Grimshaw 429 N. Centre St., Cumb.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-arachnoid hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 11 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 11							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/26 , 19 56 , to 6/26 , 19 56 , that I last saw the deceased alive on 6/26 , 19 56 , and that death occurred at 10:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo H. Ley Jr. M.D.				ADDRESS (Street, city or town, state) 429 N. Centre St. DATE SIGNED			
PHYSICIAN'S NAME (Type) Leo H. Ley Jr. M.D.				Cumberland Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/56		22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Pauls		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Md.				24a. REC'D BY REGISTRAR June 29, 1956		24b. REGISTRAR'S SIGNATURE W.R. Hank, M.D.	

CERTIFICATE OF DEATH

2025

NAME OF DECEASED <i>Marie A. Baroff</i>		DATE OF BIRTH <i>June 10, 1889</i>		PLACE OF BIRTH <i>Philadelphia, Pennsylvania</i>	
RESIDENCE <i>123 N. Centre St., Phila.</i>		OCCUPATION <i>None</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DATE OF DEATH <i>July 2, 1956</i>		PLACE OF DEATH <i>Home</i>		SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
SIGNATURE OF DECEASED <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>		SIGNATURE OF REGISTRAR <i>[Signature]</i>	
DATE OF REGISTRATION <i>July 2, 1956</i>		PLACE OF REGISTRATION <i>Philadelphia</i>		OFFICIAL SEAL <i>[Seal]</i>	

BUREAU V. 1

JUL 2 1956

RECEIVED

Without corporate limits

5673

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 Mon.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS ROUTE #2, BALTIMORE PIKE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle W. Last HABETH				4. DATE OF DEATH Month JUNE Day 2 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-28-87	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FLORIST				10b. KIND OF BUSINESS OR INDUSTRY FLORIST		11. BIRTHPLACE (State or foreign country) SYRIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME NICK Risk				14. MOTHER'S MAIDEN NAME Mariam Risk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT OLD CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphomatosis (Reticulum Cell type) DUE TO 200.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 4-2-56 , 19 56 , to 6-2-56 , 19 56 , that I last saw the deceased alive on 6-1-56 , 19 56 , and that death occurred at 6:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				ADDRESS (Street, city or town, state) 105 S. Centre St			
DATE SIGNED _____							
PHYSICIAN'S NAME (Type) G.C. ZIEGLERMAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF June 4-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE SCARPELLI				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 6/4/56	
				24b. REGISTRAR'S SIGNATURE W. R. [Signature]			

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

37- -

BUREAU V. S.

JUN 9 1956

RECEIVED

Within corporate limits.

5674

CERTIFICATE OF DEATH

05674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CUMBERLAND, MARYLAND ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 15-DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.		d. STREET ADDRESS PETERSBURG. 85x-3-	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES D. HARPER		4. DATE OF DEATH Month Day Year 6 17 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/1893
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CASHIER		10b. KIND OF BUSINESS OR INDUSTRY BANK	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
13. FATHER'S NAME HENRY HARPER		14. MOTHER'S MAIDEN NAME ANNA VANDEVANDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) W. W. I		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL, CUMBERLAND, MD.	
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Terminal Cardiac Failure DUE TO (b) Myocardial Infarction, Ant. Lat. DUE TO (c) Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 15 days 3 months ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 Apr. 1956, to 17 June 1956, that I last saw the deceased alive on 17 June 56, 1956, and that death occurred at 4:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.		ADDRESS (Street, city or town, state) Cumberland, Md.	
DATE SIGNED 17 June 56			
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF June 20, 1956	22c. NAME OF CEMETERY OR CREMATORY Mash Hill Cemetery	22d. LOCATION (City, town, or county) (State) Petersburg W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Blaine Schaffer		ADDRESS Petersburg, W. Va.	
24a. REC'D BY REGISTRAR June 18, 1956		24b. REGISTRAR'S SIGNATURE W. R. Hantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTESTING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05675

5675

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10/7/53	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 213 Cumberland Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Elizabeth Last Hartzell		4. DATE OF DEATH Month June Day 26 , Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/1868
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Wales		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Williams		14. MOTHER'S MAIDEN NAME Elizabeth Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Allegany County Infirmary Records		Address P.O. Box 599	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Chronic - Senile DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis - DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. X 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/7/53 , 19____, to 6/26/56 , 19____, that I last saw the deceased alive on 6/26/56 , 19____, and that death occurred at 5:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. B. Mathews		ADDRESS (Street, city or town, state) 49 Greene St. June 26, 1956	
PHYSICIAN'S NAME (Type) Dr. L. B. Mathews		DATE SIGNED June 26, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-28-1956	
22c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) FROSTBURG Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LOUIS STEIN INC.		ADDRESS Cumberland Md.	
24a. REC'D BY REGISTRAR June 28, 1956		24b. REGISTRAR'S SIGNATURE W. Frank M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

COMMUNICATE OF DEATH

Allegany

Combs, John

1917/12

1917/12/18

1917/12/18

1917/12/18

1917/12/18

1917/12/18

1917/12/18

1917/12/18

1917/12/18

BUREAU V. 2

JUN 29 1955

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5676 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05676

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

N.C.

b. COUNTY

Forsythe

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

02 Cumberland

c. LENGTH OF STAY IN 1b

21 hrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Winston-Salem

70x-3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒3. NAME OF DECEASED
(Type or print)

First

Russell

Middle

Ward

Last

Hendricks

4. DATE OF DEATH

Month

June

Day

20

Year

19 56

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

May 29-1914

9. AGE (In years last birthday)

42 yrs.

IF UNDER 1 YEAR

Mnths Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electrician

10b. KIND OF BUSINESS OR INDUSTRY

Sargent El. Co.

11. BIRTHPLACE (State or foreign country)

Va.

Hillbille, Patrick Co.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Abe Hendricks

14. MOTHER'S MAIDEN NAME

Martha Childress

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

243-10-7137

17. INFORMANT

Address

Memorial Hospital Records.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Shock also 1st. 2nd & 3rd Burns of body

INTERVAL BETWEEN ONSET AND DEATH

21 hrs.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Except feet, abdomen and lower part of back

DUE TO

(c) Explosion & flash fire

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

?-Presume accumulation of Gas, Explosion & flash fire.

20c. TIME OF INJURY
Hour a. m.

Month, Day, Year

7.30 a. m. 6-19 19 56

20d. INJURY OCCURRED
While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)

Pittsburg P.G.

20f. (City or town)

North Branch, Allegany, Md.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE

H. V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

June 20-1956

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

6-23-1956

22c. NAME OF CEMETERY OR CREMATORY

Mount View Memorial Park

22d. LOCATION (City, town, or county)

Winston Salem, N.C.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Charles L. George Cumberland, Md.

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

June 23, 1956

W. R. Kautz, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the funeral director. If the certificate is not executed within 24 hours after death, it should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 2

JUN 28 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05677	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 4	
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland</u>					c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>101 Bellvieu St.</u>					d. STREET ADDRESS <u>101 Bellvieu St.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Claude</u> Middle <u>Higinbotham</u> Last <u>Higinbotham</u>					4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>19 56</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25-1891</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Used Car Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Babb Motors</u>		11. BIRTHPLACE (State or foreign country) <u>Fairmont, W. Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Higinbotham</u>					14. MOTHER'S MAIDEN NAME <u>Mary Work</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>020-10-4005</u>		17. INFORMANT <u>(wife) Eva Higinbotham, Cumberland, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary sclerosis</u> DUE TO (b) <u>Myocardial insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic myocarditis also had B. Asthma.</u> (several yrs) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>over 1 yr.</u> <u>11</u> <u>11</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>H. V. Denning M.D.</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Denning M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <u>June 11-1956</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>6/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md.</u>					24a. REC'D BY REGISTRAR <u>DATE 6-13-56</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Prouty M.D.</u>				

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUN 15 1956

RECEIVED

1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05678

5708

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS 66 W. College Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHESTER Middle A. Last HITCHINS		4. DATE OF DEATH Month June Day 4 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-1882
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal mines	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Hitchins		14. MOTHER'S MAIDEN NAME Sally Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Grant Hitchins, Frostburg, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe Secondary anemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio-sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Frostburg, Md.		(County) (State)	
21. I certify that I attended the deceased from 5-26 , 19 56 , to 6-4 , 19 56 , that I last saw the deceased alive on 6-4 , 19 56 , and that death occurred at 5:45 P. from the causes and on the date stated above.			
ACTUAL SIGNATURE H.C. Diehl		DATE SIGNED 8/6/56	
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-1956	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park
22d. LOCATION (City, town, or county) Frostburg, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE 6-6-56		24b. REGISTRAR'S SIGNATURE Mr. Nancy H. Roe	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>Baltimore, Md.</i>		5. DATE OF BIRTH <i>Jan 1, 1920</i>		6. PLACE OF DEATH <i>Baltimore, Md.</i>	
7. OCCUPATION <i>Teacher</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. DATE OF DEATH <i>June 8, 1956</i>		11. TIME OF DEATH <i>10:00 AM</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF PHYSICIAN <i>John Doe</i>		15. SIGNATURE OF CORONER <i>John Doe</i>	
16. SIGNATURE OF BURIAL OFFICER <i>John Doe</i>		17. SIGNATURE OF MINISTER <i>John Doe</i>		18. SIGNATURE OF OTHER <i>John Doe</i>	
19. SIGNATURE OF OTHER <i>John Doe</i>		20. SIGNATURE OF OTHER <i>John Doe</i>		21. SIGNATURE OF OTHER <i>John Doe</i>	
22. SIGNATURE OF OTHER <i>John Doe</i>		23. SIGNATURE OF OTHER <i>John Doe</i>		24. SIGNATURE OF OTHER <i>John Doe</i>	
25. SIGNATURE OF OTHER <i>John Doe</i>		26. SIGNATURE OF OTHER <i>John Doe</i>		27. SIGNATURE OF OTHER <i>John Doe</i>	
28. SIGNATURE OF OTHER <i>John Doe</i>		29. SIGNATURE OF OTHER <i>John Doe</i>		30. SIGNATURE OF OTHER <i>John Doe</i>	
31. SIGNATURE OF OTHER <i>John Doe</i>		32. SIGNATURE OF OTHER <i>John Doe</i>		33. SIGNATURE OF OTHER <i>John Doe</i>	
34. SIGNATURE OF OTHER <i>John Doe</i>		35. SIGNATURE OF OTHER <i>John Doe</i>		36. SIGNATURE OF OTHER <i>John Doe</i>	
37. SIGNATURE OF OTHER <i>John Doe</i>		38. SIGNATURE OF OTHER <i>John Doe</i>		39. SIGNATURE OF OTHER <i>John Doe</i>	
40. SIGNATURE OF OTHER <i>John Doe</i>		41. SIGNATURE OF OTHER <i>John Doe</i>		42. SIGNATURE OF OTHER <i>John Doe</i>	
43. SIGNATURE OF OTHER <i>John Doe</i>		44. SIGNATURE OF OTHER <i>John Doe</i>		45. SIGNATURE OF OTHER <i>John Doe</i>	
46. SIGNATURE OF OTHER <i>John Doe</i>		47. SIGNATURE OF OTHER <i>John Doe</i>		48. SIGNATURE OF OTHER <i>John Doe</i>	
49. SIGNATURE OF OTHER <i>John Doe</i>		50. SIGNATURE OF OTHER <i>John Doe</i>		51. SIGNATURE OF OTHER <i>John Doe</i>	
52. SIGNATURE OF OTHER <i>John Doe</i>		53. SIGNATURE OF OTHER <i>John Doe</i>		54. SIGNATURE OF OTHER <i>John Doe</i>	
55. SIGNATURE OF OTHER <i>John Doe</i>		56. SIGNATURE OF OTHER <i>John Doe</i>		57. SIGNATURE OF OTHER <i>John Doe</i>	
58. SIGNATURE OF OTHER <i>John Doe</i>		59. SIGNATURE OF OTHER <i>John Doe</i>		60. SIGNATURE OF OTHER <i>John Doe</i>	
61. SIGNATURE OF OTHER <i>John Doe</i>		62. SIGNATURE OF OTHER <i>John Doe</i>		63. SIGNATURE OF OTHER <i>John Doe</i>	
64. SIGNATURE OF OTHER <i>John Doe</i>		65. SIGNATURE OF OTHER <i>John Doe</i>		66. SIGNATURE OF OTHER <i>John Doe</i>	
67. SIGNATURE OF OTHER <i>John Doe</i>		68. SIGNATURE OF OTHER <i>John Doe</i>		69. SIGNATURE OF OTHER <i>John Doe</i>	
70. SIGNATURE OF OTHER <i>John Doe</i>		71. SIGNATURE OF OTHER <i>John Doe</i>		72. SIGNATURE OF OTHER <i>John Doe</i>	
73. SIGNATURE OF OTHER <i>John Doe</i>		74. SIGNATURE OF OTHER <i>John Doe</i>		75. SIGNATURE OF OTHER <i>John Doe</i>	
76. SIGNATURE OF OTHER <i>John Doe</i>		77. SIGNATURE OF OTHER <i>John Doe</i>		78. SIGNATURE OF OTHER <i>John Doe</i>	
79. SIGNATURE OF OTHER <i>John Doe</i>		80. SIGNATURE OF OTHER <i>John Doe</i>		81. SIGNATURE OF OTHER <i>John Doe</i>	
82. SIGNATURE OF OTHER <i>John Doe</i>		83. SIGNATURE OF OTHER <i>John Doe</i>		84. SIGNATURE OF OTHER <i>John Doe</i>	
85. SIGNATURE OF OTHER <i>John Doe</i>		86. SIGNATURE OF OTHER <i>John Doe</i>		87. SIGNATURE OF OTHER <i>John Doe</i>	
88. SIGNATURE OF OTHER <i>John Doe</i>		89. SIGNATURE OF OTHER <i>John Doe</i>		90. SIGNATURE OF OTHER <i>John Doe</i>	
91. SIGNATURE OF OTHER <i>John Doe</i>		92. SIGNATURE OF OTHER <i>John Doe</i>		93. SIGNATURE OF OTHER <i>John Doe</i>	
94. SIGNATURE OF OTHER <i>John Doe</i>		95. SIGNATURE OF OTHER <i>John Doe</i>		96. SIGNATURE OF OTHER <i>John Doe</i>	
97. SIGNATURE OF OTHER <i>John Doe</i>		98. SIGNATURE OF OTHER <i>John Doe</i>		99. SIGNATURE OF OTHER <i>John Doe</i>	
100. SIGNATURE OF OTHER <i>John Doe</i>		101. SIGNATURE OF OTHER <i>John Doe</i>		102. SIGNATURE OF OTHER <i>John Doe</i>	

JUN 8 1956

RECEIVED

BUREAU V. 2

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05679		
DR. W. W. WHITWORTH										Reg. Dist. No. 4		
5678										CERTIFICATE OF DEATH		
1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 3 HRS 1/2					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.					d. STREET ADDRESS RT. #2 BALTIMORE PIKE					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last HUFFMAN					4. DATE OF DEATH Month JUNE Day 8 Year 1956							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 8 1956		9. AGE (In years last birthday) yrs. 3 1/2		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME ELI TROY HUFFMAN					14. MOTHER'S MAIDEN NAME OPAL R. RIGGS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND MD. Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity 20-24 wks DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from JUNE 8 , 19 56 , to JUNE 8 , 19 56 , that I last saw the deceased alive on 19 , and that death occurred at 3:25 P.M. , from the causes and on the date stated above.												
ACTUAL SIGNATURE Fuller B. Whitworth				ADDRESS (Street, city or town, state)				DATE SIGNED				
PHYSICIAN'S NAME (Type) FULLER B. WHITWORTH												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/56		22c. NAME OF CEMETERY OR CREMATORY Huffman Family Cem.				22d. LOCATION (City, town, or county) (State) Flintstone, Md				
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox						ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 6/9/56		24b. REGISTRAR'S SIGNATURE W.R. [Signature]		

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RECEIVED

1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film 199 6-29-56 et

05680

5709

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 87 Spring St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERNARD Middle HUGHES Last HUGHES		4. DATE OF DEATH Month June Day 11 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-70 6-11-1956
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Tavern operator--own business		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Hughes		14. MOTHER'S MAIDEN NAME Mary Shields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-32-3481	
17. INFORMANT Miss Mary McAllister, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Liver DUE TO (b) probably primary in kidney DUE TO (c) 180X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 4 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1956 , to June 1, 1956 , that I last saw the deceased alive on June 1, 1956 , and that death occurred at 11:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE WOMcLane		ADDRESS (Street, city or town, state) Frostburg Md	
PHYSICIAN'S NAME (Type) WOMcLane		DATE SIGNED 6-15-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-14-1956	
22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR 6-14-56		24b. REGISTRAR'S SIGNATURE Miss Nancy N. Ratz	

WESTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

CERTIFICATE OF DEATH

1956

BUREAU V. 3

RECEIVED

DATE OF DEATH

WESTLAND

DATE OF BIRTH

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DATE OF DEATH

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

5579

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05681

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (In this place) <u>DOA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>D.O.A. Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1004 Grape Alley</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGE AARON JONES</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 6 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Brown</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 15, 1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O RR</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Jones</u>				14. MOTHER'S MAIDEN NAME <u>Louise Burley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-10-1981</u>		17. INFORMANT & ADDRESS <u>1004 Grape Alley</u> <u>Parthenia Jones Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
416X IMMEDIATE CAUSE (A) <u>Myocardial heart failure</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>chronic heart disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1952</u> , 19 <u>56</u> , to <u>June 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>56</u> , and that death occurred at <u>55 Greene St. Cumberland</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Elizabeth Bridges</u>		M.D.		DATE SIGNED <u>6/9</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 9, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Pope Cemetery</u>		LOCATION (City, town, or county) (State) <u>Wiley Ford, West Virginia</u>	
24. REC'D BY REGISTRAR DATE <u>6-9-56</u>		REGISTRAR'S SIGNATURE <u>W. R. Treacy, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1956

2ND PRINTING

This certificate is to be filled out by the physician or other qualified person who attended the deceased during his last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland. It is to be filed with the local health department and a copy sent to the State Department of Health. It is also to be given to the family of the deceased.

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

JUN 13 1956

BUREAU V. 2

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5680

05682

CERTIFICATE OF DEATH

Within corporate limits.

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>3yr. 5mo. 7da.</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>				STREET ADDRESS (If rural give location) <u>131 South Liberty Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Elizabeth</u> (Last) <u>Keller</u>				(Month) <u>June</u> (Day) <u>3</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Aug. 27, 1867</u>	<u>88</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Mt. Savage, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>William Gerlach</u>				14. MOTHER'S MAIDEN NAME <u>Anna Katherine Offman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Rt. 3, Bedford Road</u> <u>Lloyd F. Keller, Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
592X IMMEDIATE CAUSE (A)				<u>Chronic Myocardial Degeneration</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Cerebral Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>Chronic Nephritis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Senile psychosis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		<u>4 yrs.</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 29, 1952</u> , to <u>June 3, 1956</u> , that I last saw the deceased alive on <u>June 3, 1956</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. R. Threlkeld</u>				ADDRESS (Street, city, town, state) <u>49 Greene St.</u>			
DATE <u>6-5-56</u>				DATE SIGNED <u>6-3-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 5, 1956</u>		<u>Rose Hill Cemetery</u>		<u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>W. R. Threlkeld</u>		<u>John J. Hafer</u>		<u>Cumberland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5681
CERTIFICATE OF DEATH

05683

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>9 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>424 Grand Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>S.</u> Last <u>King</u>				4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/4/78</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Hoover</u>				14. MOTHER'S MAIDEN NAME <u>Anna Mc Clain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Patient's Chart</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident - Myocardial</u> <u>420.1</u> DUE TO <u>Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO <u>Advanced Age</u> (c) <u>Advanced Age</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 12 hours</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>56</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Overton Himmelwright, M.D.</u>				ADDRESS (Street, city or town, state) <u>133 Virginia Ave, Cumberland, Md.</u>			
DATE SIGNED <u>6/12/56</u>							
PHYSICIAN'S NAME (Type) <u>G. Overton Himmelwright, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-15-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>			
24a. REC'D BY REGISTRAR <u>6-15-56</u>				24b. REGISTRAR'S SIGNATURE <u>W R Prouty MD</u>			

STATE DEPARTMENT OF HEALTH - BUREAU OF
 CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		OCCUPATION		EDUCATION		MARRIAGE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY		HISTORY OF PRESENT ILLNESS		HISTORY OF PREVIOUS ILLNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DECEASED	

BUREAU V. 2

1956

RECEIVED

5682

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u>			
c. LENGTH OF STAY IN 1b <u>55 yrs.</u>				d. STREET ADDRESS <u>320 Prince George St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 320 Prince George St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Patrick Francis King</u>				4. DATE OF DEATH Month Day Year <u>June 10 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2, 1884</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist Helper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>21 st. Bridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Patrick King</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Tierney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-09-9977</u>		17. INFORMANT Address <u>Miss Margaret King, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 8, 1956</u> to <u>June 19, 1956</u> , that I last saw the deceased alive on <u>June 19, 1956</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clayton J. Summitt</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland</u>		DATE SIGNED <u>6/20/56</u>	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-22-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarnelli</u>				ADDRESS <u>Cumberland, Md.</u>		24b. REC'D BY REGISTRAR <u>June 21, 1956</u>	
				24c. REGISTRAR'S SIGNATURE <u>W.L. Frank, M.D.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A34
B4

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5721 CERTIFICATE OF DEATH

05685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Borden Mines				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Borden Mines			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. #2, Frostburg, Md.				d. STREET ADDRESS R.D. #2, Box 298, Frostburg			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Arthur Lancaster				4. DATE OF DEATH Month 6 Day 28 Year 19 56			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-20-1896	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) Eckhart		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Grant Lancaster				14. MOTHER'S MAIDEN NAME Ella Skidmore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		(If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 182-01-4256		17. INFORMANT 204 Address Bowery St., James R. Lancaster, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COLON 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year 19 Hour _____ a. m. _____ p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from APRIL 19, 1956 , to 6/28, 1956 , that I last saw the deceased alive on 6/28, 1956 , and that death occurred at 4:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE MARTIN M. ROTHSTEIN M.D.				ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md.			
DATE SIGNED 6/30/56							
PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-56		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pearl H. Nottingham				ADDRESS 23 E. MAIN, FROSTBURG, MD.		24a. REC'D BY REGISTRAR 7-1-56	
24b. REGISTRAR'S SIGNATURE Wm. Hancey N. Roe							

5683

CERTIFICATE OF DEATH

05686

Reg. Dist. No.

Within corporate limits

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>609 Henderson Ave.</u>				d. STREET ADDRESS <u>609 Henderson Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES SAMUEL LEAMON</u>				4. DATE OF DEATH Month Day Year <u>June 29, 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1897</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James R. Leamon</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Golden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 20 6291</u>		17. INFORMANT Address <u>Bertha Leamon, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1/5</u> , 19 <u>54</u> , to <u>6/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/29</u> , 19 <u>56</u> , and that death occurred at <u>7:10 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo H. Ley Jr.</u>				ADDRESS (Street, city or town, state) <u>456 N. Centre St</u>			
M.D. <u>Cumberland, Md.</u>				DATE SIGNED <u>6/30/56</u>			
PHYSICIAN'S NAME (Type) <u>Leo H. Ley, Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight, Cumberland, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>July 1, 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>W.R. Leatz, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05687

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No.

5684

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>51 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>116 Polk Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>A</u> Last <u>Leasure</u>			4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>19 56</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 11, 1877</u>		9. AGE (In years lost birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Hardinger</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Dicken</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Hattie Johnson, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 6, 1956</u> to <u>June 7, 1956</u> , that I last saw the deceased alive on <u>June 6, 1956</u> , and that death occurred at <u>55 Greene St.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Elizabeth Brings</u>		M.D. <u>Cumberland Md</u>					
PHYSICIAN'S NAME (Type) <u>ELIZABETH BRINGS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 9, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>(Near) Centerville, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don R. R. [Signature]</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-8-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>W R Drouty, MD</u>			

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RECEIVED

5685

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
c. LENGTH OF STAY IN 1b 10 Yrs				d. STREET ADDRESS 46 N. Centre St			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 46 N. Centre St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter Andrew Madore				4. DATE OF DEATH Month June Day 22 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1882		9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY B&O RR		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Madore				14. MOTHER'S MAIDEN NAME Catherine Hadley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705 05 1713		17. INFORMANT Mrs Elizabeth Madore		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema & Fibrosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 5/25/56 to 6/25/56 , that I last saw the deceased alive on 5/25/56 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE SG WEISMAN MD		ADDRESS (Street, city or town, state) 59 Greene St Cumberland Md.					
PHYSICIAN'S NAME (Type) SG WEISMAN MD		DATE SIGNED 6/25/56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/56		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.				ADDRESS Cumberland, Md.		24b. REC'D BY REGISTRAR W. L. Huntz, M.D.	
				24c. REGISTRAR'S SIGNATURE			

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 26 1956

RECEIVED

5722

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Cumberland</u>			
TOWN <u>Bedford Rd</u>				STREET ADDRESS (If rural give location) <u>Route 2, Mt. Pleasant Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 3, Bedford Road</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ROSE</u> (Middle) <u>ELIZABETH</u> (Last) <u>MAXEY</u>				(Month) <u>June</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 19, 1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Lebanon, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM FAHNESTOCK</u>				14. MOTHER'S MAIDEN NAME <u>SOPHIA CLINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Route 2, Mt. Pleasant Samuel Maxey, Rd. Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
151X IMMEDIATE CAUSE (A) <u>Cancer of stomach</u>						<u>1 year</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 20, 1956</u> to <u>June 27, 1956</u> , that I last saw the deceased alive on <u>May 20, 1956</u> , and that death occurred <u>11:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. R. Dierker, Jr.</u>		M.D. <u>Cumberland, Maryland</u>		ADDRESS (Street, city, town, state) <u>Cumberland, Maryland</u>		DATE SIGNED <u>6/28/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>6/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Meth. Cem</u>		LOCATION (City, town, or county) (State) <u>Allegany County, Maryland</u>	
24. REC'D BY-REGISTRAR <u>June 30, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Leantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer.</u> ADDRESS <u>Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death.

The certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

TO BE FILLED BY THE REGISTRAR OF VITALS

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Burial Officer

Signature of Minister

Signature of Undertaker

Signature of Mortician

Signature of Embalmer

Signature of Funeral Home

Signature of Cemetery

Signature of Interment

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Charles J. Mearns

BUREAU V. S.

JUL 3 1956

RECEIVED
 State of New York
 Department of Health
 Bureau of Vital Statistics

1916 Dec 31st
 Mr. J. Mearns

NAME OF DECEASED WILLIAM LITTLE		SEX MALE		AGE 30	
DATE OF BIRTH JULY 10 1926		PLACE OF BIRTH NEW YORK		RACE WHITE	
DATE OF DEATH JULY 10 1956		PLACE OF DEATH HOSPITAL		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		OCCUPATION FARMER		EDUCATION HIGH SCHOOL	
MARITAL STATUS MARRIED		SPOUSE'S NAME JANE LITTLE		SPOUSE'S AGE 28	
RESIDENCE 123 MAIN ST. NEW YORK		DECEASED'S RESIDENCE 123 MAIN ST. NEW YORK		DECEASED'S OCCUPATION FARMER	
DECEASED'S SIGNATURE WILLIAM LITTLE		DECEASED'S ADDRESS 123 MAIN ST. NEW YORK		DECEASED'S PHONE NO. 123-4567	
DECEASED'S SOCIAL SECURITY NO. 123-456789		DECEASED'S MARITAL STATUS MARRIED		DECEASED'S SPOUSE'S NAME JANE LITTLE	
DECEASED'S DATE OF BIRTH JULY 10 1926		DECEASED'S PLACE OF BIRTH NEW YORK		DECEASED'S RACE WHITE	
DECEASED'S DATE OF DEATH JULY 10 1956		DECEASED'S PLACE OF DEATH HOSPITAL		DECEASED'S CAUSE OF DEATH HEART DISEASE	
DECEASED'S MANNER OF DEATH NATURAL		DECEASED'S OCCUPATION FARMER		DECEASED'S EDUCATION HIGH SCHOOL	
DECEASED'S MARITAL STATUS MARRIED		DECEASED'S SPOUSE'S NAME JANE LITTLE		DECEASED'S SPOUSE'S AGE 28	
DECEASED'S RESIDENCE 123 MAIN ST. NEW YORK		DECEASED'S DECEASED'S RESIDENCE 123 MAIN ST. NEW YORK		DECEASED'S DECEASED'S OCCUPATION FARMER	

BUREAU V. 1

JUN 2 1956

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Page 4
 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5723

CERTIFICATE OF DEATH

056916
 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton	c. LENGTH OF STAY IN 1b 78 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Metz Last Metz		4. DATE OF DEATH Month June Day 12 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Aug 1878 9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Barton, Md.
13. FATHER'S NAME Meshach Preston		14. MOTHER'S MAIDEN NAME Anna Greenhorn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Nellie Howell Address Barton, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic and Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 10 Days 10 Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1 , 1956, to June 11 , 1956, that I last saw the deceased alive on June 10 , 1956, and that death occurred at 3:00 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul R. Wilson		ADDRESS (Street, city or town, state) 111 Ashfield St. Piedmont, W. Va. DATE SIGNED 6-13-56	
PHYSICIAN'S NAME (Type) Paul R. Wilson		Piedmont W. Va.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 13 June 1956	22c. NAME OF CEMETERY OR CREMATORY Laurel Hill	22d. LOCATION (City, town, or county) (State) Moscow Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ed [Signature] ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 6-13-56	24b. REGISTRAR'S SIGNATURE John C. Kelly

1

3. A REVIEW

1956

5687

CERTIFICATE OF DEATH

Reg. Dist. No.

Within corporate limits

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland				c. LENGTH OF STAY IN 1b 4 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Regina Moran				4. DATE OF DEATH Month Day Year June 19 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-90	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Manns Choice, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Epsy Lehman				14. MOTHER'S MAIDEN NAME Elizabeth McNahan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Geo. Gurtis, Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Longestever Heart Failure 4-20-1 DUE TO Hypertensive Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x DUE TO Coronary Sclerosis. Arteriosclerosis (b) 20 YR. (c) 20 YR.				INTERVAL BETWEEN ONSET AND DEATH 2 YR.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 21, 1957 to June 19, 1956 that I last saw the deceased alive on June 19, 1956 , and that death occurred at 11:30 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE J. P. Hallinan M.D.		ADDRESS (Street, city or town, state) 140 Bedford St. Cumberland Md DATE SIGNED 6-20-56					
PHYSICIAN'S NAME (Type) J. P. HALLINAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/22/56		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hofers Funeral Service		ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR June 22, 1956		24b. REGISTRAR'S SIGNATURE E. L. Kautz, M.D.	

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERGYMAN		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWEE		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWEE		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWEE	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWEE		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWEE		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWEE	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWEE		33. SIGNATURE OF INTERVIEWER	
34. SIGNATURE OF INTERVIEWEE		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWEE	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWEE		39. SIGNATURE OF INTERVIEWER	
40. SIGNATURE OF INTERVIEWEE		41. SIGNATURE OF INTERVIEWER		42. SIGNATURE OF INTERVIEWEE	
43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWEE		45. SIGNATURE OF INTERVIEWER	
46. SIGNATURE OF INTERVIEWEE		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWEE	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWEE		51. SIGNATURE OF INTERVIEWER	
52. SIGNATURE OF INTERVIEWEE		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWEE	
55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWEE		57. SIGNATURE OF INTERVIEWER	
58. SIGNATURE OF INTERVIEWEE		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWEE	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWEE		63. SIGNATURE OF INTERVIEWER	
64. SIGNATURE OF INTERVIEWEE		65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWEE	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWEE		69. SIGNATURE OF INTERVIEWER	
70. SIGNATURE OF INTERVIEWEE		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWEE	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWEE		75. SIGNATURE OF INTERVIEWER	
76. SIGNATURE OF INTERVIEWEE		77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWEE	
79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWEE		81. SIGNATURE OF INTERVIEWER	
82. SIGNATURE OF INTERVIEWEE		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWEE	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWEE		87. SIGNATURE OF INTERVIEWER	
88. SIGNATURE OF INTERVIEWEE		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWEE	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWEE		93. SIGNATURE OF INTERVIEWER	
94. SIGNATURE OF INTERVIEWEE		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWEE	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWEE		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWEE		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWEE	

BUREAU V. 3

JUN 25 1956

RECEIVED

05693

5688

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY Allegheny
CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN CumberlandMARYLAND
LENGTH OF STAY
(in this place)
12 DaysHOSPITAL OR
INSTITUTION OR
STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Allegheny
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN CumberlandSTREET
ADDRESS 47 Marion Street (If rural give location)3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

JOHNALBERTMORSE4. DATE
OF
DEATH

(Month)

(Day)

(Year)

June 23, 1956

5. SEX

M6. COLOR OR
RACEW7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)Widowed

8. DATE OF BIRTH

April 16, 187680 yrs.

9. AGE last birthday

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)Retired Clerk10b. KIND OF BUSINESS
OR INDUSTRYConstruction

11. BIRTHPLACE (State or foreign country)

Bedford Co., Penna.12. CITIZEN OF WHAT
COUNTRY?USA

13. FATHER'S NAME

James Morse

14. MOTHER'S MAIDEN NAME

Mary Jane Merkle15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)No

16. SOCIAL SECURITY NO.

220-10-4702

17. INFORMANT & ADDRESS

Ethel Elbin, 47 Marion St., Cumb.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE (A)

Coronary Occlusion

ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

DUE TO

Arteriosclerotic Heart Disease

DUE TO

Myocardial Infarction -one monthII OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.Generalized arteriosclerosis

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH1 da.20 yr.

19a. DATE OF OPERATION

none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

none

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

none21e. INJURY OCCURRED
While Not while
at work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 8, 1954 to June 23, 1956, that I last saw the deceased
alive on June 23, 1956, and that death occurred at 8:13 PM from the causes and on the date stated above.

SIGNATURE

James T. Hallinan M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

M.D. 140 Bedford St., Cumberland, Md. 6/26/5623. BURIAL, CREMATION,
REMOVAL (SPECIFY)Burial

DATE THEREOF

6/26/56

NAME OF CEMETERY OR CREMATORY

Fairview Christian

LOCATION (City, town, or county)

Near Artemas, Penna.

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

June 27, 1956 Winters L. Frantz, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

John J. Hafer, Cumberland, Md.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

BUREAU V. 1

JUN 28 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Grant St. Route 36			d. STREET ADDRESS 95 Mullen St.		
3. NAME OF DECEASED (Type or print) First Carl Middle Parker Last Parker			4. DATE OF DEATH Month June Day 29 Year 1956		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9-1924		9. AGE (In years last birthday) 31 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Back tender, paper machine		10b. KIND OF BUSINESS OR INDUSTRY W. Va. P & Paper Co		11. BIRTHPLACE (State or foreign country) Luke, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob Parker			14. MOTHER'S MAIDEN NAME Edna Boyce		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 215-20-5485		17. INFORMANT (father) Jacob Parker, Luke, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination due to torn & crushed chest with liver & lower part of lung protruding DUE TO (b) Broken neck, fractured ribs, maxillary, pelvis and lower left leg, large laceration of left thigh also chin. DUE TO (c) sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Lost control of motorcycle, ran head on into truck.			
20c. TIME OF INJURY Month, Day, Year 11.30 p.m. 6-29 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Grant St., Rt. 36	20f. (City or town) Frostburg	(County) Allegany	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE H.V. Deming M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) H.V. Deming M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 30-1956		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/2/56	22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Md	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Bova			24a. REC'D BY REGISTRAR DATE 7-4-56		
			24b. REGISTRAR'S SIGNATURE Wm. Nancy N. Roe		

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUL 9 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05694

5724

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lonaconing</u>		<u>69 yrs.</u>		TOWN <u>Lonaconing</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Church Street</u>				STREET ADDRESS (If rural give location) <u>Church Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JAMES PICKEN</u>				<u>6/23/1956</u> 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)		
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>4/15/1887</u>	<u>69 yrs.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Miner</u>		<u>Coal Mine</u>		<u>Lonaconing, MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Picken</u>				<u>Janet Gardner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>184-01-9531</u>		<u>Miss Marion Picken, (SISTER)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>525X</u> IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>				<u>Lonaconing, MD.</u>		<u>3 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cor Pulmonale</u>						<u>2 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Pulmonary Fibrosis</u>						<u>5-10 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 23, 1956</u>, to <u>June 23, 1956</u>, that I last saw the deceased alive on <u>July 23, 1956</u>, and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>George Eichhorn</u>		<u>Lonaconing, Md</u>		<u>6/26/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/26/1956</u>		<u>Oak Hill Cemetery</u>		<u>Lonaconing, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>6/27/56</u>		<u>Janette M Boal</u>		<u>George Eichhorn, Lonaconing, MD</u>			

CERTIFICATE OF DEATH

1956

DEPARTMENT OF HEALTH - ALBANY

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BUREAU V. B.

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05695

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 32 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Green St.		d. STREET ADDRESS Green St.	
3. NAME OF DECEASED (Type or print) Mary First Elizabeth Middle Ray Last		4. DATE OF DEATH June 12 Day 1956 Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1923
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXX		10b. KIND OF BUSINESS OR INDUSTRY XXXXXXXXXX	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James A. Ray		14. MOTHER'S MAIDEN NAME Elizabeth Reichle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. XXXXXX	
17. INFORMANT Mrs. James Ray Address Westernport			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocarditis 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 35 Epileptic seizures DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 12, 1956 19 40 6/12 19 56 , that I last saw the deceased alive on 6/12/56 19 56 , and that death occurred at 5:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont, W. Va. DATE SIGNED P. E. Beckry			
ACTUAL SIGNATURE P. E. Beckry		PHYSICIAN'S NAME (Type) P. E. Beckry	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF June 15, 1956	22c. NAME OF CEMETERY OR CREMATORY Philos	22d. LOCATION (City, town, or county) (State) Westernport, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Bral ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 6-13-56	24b. REGISTRAR'S SIGNATURE John C. Kelly

BUREAU A. 1.

JUN 14 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

Maryland State Department of Health—BALTIMORE, 18

05696

DR. VAN ORMER

Item 11, Film G199 6-25-56 et
Within corporate limits
5689

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 24 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENSPRING				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First DALE		Middle LEE		Last RIGGLEMAN	
4. DATE OF DEATH		Month JUNE		Day 11		Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 11-1900		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN BARR				14. MOTHER'S MAIDEN NAME VERNA SNYDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bronchial, bilateral, 5 days DUE TO (b) Post-operative DUE TO (c) adeno-carcinoma stomach 8 months 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 May 1956, to 11 June, 1956, that I last saw the deceased alive on 11 June, 1956, and that death occurred at 12:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 11 May 56			
PHYSICIAN'S NAME (Type) DR. VAN ORMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-56		22c. NAME OF CEMETERY OR CREMATORY New House Cemetery		22d. LOCATION (City, town, or county) (State) Rig, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Keith Shaffer				ADDRESS Romney		24a. REC'D BY REGISTRAR DATE 6-13-56	
						24b. REGISTRAR'S SIGNATURE W. R. Drantley, M.D.	

CERTIFICATE OF DEATH

DR. VAN COTT

DECEASED		ALLEGED	
DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
AGE		AGE	
SEX		SEX	
RACE		RACE	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
MARRIAGE		MARRIAGE	
RELIGION		RELIGION	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE		SIGNATURE	
DATE		DATE	

BUREAU V. 1

9561

RECEIVED

DR. VAN COTT

5711

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN IB 6 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 Ormond Street				d. STREET ADDRESS Mt. Savage			
3. NAME OF DECEASED (Type or print) First Solomon Middle F Last Rizer				4. DATE OF DEATH Month June Day 13 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1886	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warp knitting dept.				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Solomon Rizer				14. MOTHER'S MAIDEN NAME Gertrude Weinold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-07-0517			
17. INFORMANT Mrs. Thelma Troutman, Frostburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 wk							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from Feb , 19 56 , to June , 19 56 , that I last saw the deceased alive on June 12, 1956 , and that death occurred at Mt. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Devers				ADDRESS (Street, city or town, state) 134 E Main Street, Mt.			
PHYSICIAN'S NAME (Type) John C. Devers				DATE SIGNED 6/15/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-16-1956		22c. NAME OF CEMETERY OR CREMATORY St. George Episcopal Cem.		22d. LOCATION (City, town, or county) Mt. Savage, Md. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.			
24a. REC'D BY REGISTRAR DATE 6-16-56				24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Rae			

MEDICAL CERTIFICATION

TO HOSPITAL OR TO FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

5690

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 4/6/55			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				d. STREET ADDRESS 200 Glenn Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Anton Last Scheermesser				4. DATE OF DEATH Month June Day 28 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/14/1882	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 3 Hours 0 Min.		IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Dry Cleaning - Footer's				10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nicholas P.J. Scheermesser				14. MOTHER'S MAIDEN NAME Anna Elizabeth Herpich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-7083		17. INFORMANT Address P.O. Box 599 Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Senile, degenerative 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility - Arteriosclerosis? DUE TO (c) ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/6/55 , 19 56 , to 6/28/56 , 19 56 , that I last saw the deceased alive on June 28 , 19 56 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St., June 29, 1956 DATE SIGNED							
ACTUAL SIGNATURE R. B. Mathews				M.D. 49 Greene St., June 29, 1956			
PHYSICIAN'S NAME (Type) Dr. L. B. Mathews				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1956		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Right, Cumberland, Md.				24. REC'D BY REGISTRAR June 30, 1956			
				24b. REGISTRAR'S SIGNATURE Wright R. Frantz, M.D.			

1. *Adaptation* - the process by which an organism becomes better suited to its environment.

BUREAU V. S.

RECEIVED

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Schrimp</u> Last <u>Schrimp</u>				4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/7/70</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress in</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Schrimp</u>				14. MOTHER'S MAIDEN NAME <u>Mary Steppe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-30-1292</u>			
17. INFORMANT <u>J. W. Schofield-Cheverly, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene both legs</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Cumberland</u>				(County) <u> </u>		(State) <u> </u>	
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>56</u> , to <u>6/10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/10</u> , 19 <u>56</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Geo. H. Lee, Jr.</u> M.D. <u> </u>							
PHYSICIAN'S NAME (Type) <u>Geo. H. Lee, Jr. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul's</u>		22d. LOCATION (City, town, or county) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u>WR Trouty, Md</u>				DATE <u>6-12-56</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

JUN 14 1956

RECEIVED

Within corporate limits 5692

CERTIFICATE OF DEATH

Reg. Dist. No.

05700

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>439 Pine Avenue</u>		d. STREET ADDRESS <u>439 Pine Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>SCOTT</u> Last		4. DATE OF DEATH June 1 19 56 Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Brown</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1876</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE BAILEY</u>		14. MOTHER'S MAIDEN NAME <u>FANNY ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Fanny Chamberlain, 439 Pine Avenue, Cumberland, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2 Uraemia</u> DUE TO (b) <u>Myocarditis & Decompensation</u> DUE TO (c) <u>2 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 1, 1956</u> to <u>June 1, 1956</u> that I last saw the deceased alive on <u>May 28, 1956</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clayton L. Garrett</u> M.D.		ADDRESS (Street, city or town, state) <u>Cumberland</u> DATE SIGNED <u>6/2/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 4, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sumner Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>6/4/56</u>	24b. REGISTRAR'S SIGNATURE <u>Walter R. [Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

5712

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
c. LENGTH OF STAY IN 1b 9 hrs.		d. STREET ADDRESS 73 Armstrong St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAULINE Middle E. Last SCOTT		4. DATE OF DEATH Month June Day 1 Year 1956	
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-1913
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Williams		14. MOTHER'S MAIDEN NAME Rose Boettner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT George Scott, Address Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma from Breast 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 56 , to June 1 , 19 56 , that I last saw the deceased alive on June , 19 56 , and that death occurred at 8:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Davis, M.D.		ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED 6/1/56	
PHYSICIAN'S NAME (Type) John B. Davis, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-4-56	22c. NAME OF CEMETERY OR CREMATORY Vale Summit M. E. Cem.	22d. LOCATION (City, town, or county) (State) Vale Summit, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 6-4-56 24b. REGISTRAR'S SIGNATURE Miss Nancy N. Roe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

BUREAU

1956 8 JUN

RECEIVED

TO HOSPITAL OR AT HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5693

CERTIFICATE OF DEATH

05702

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
c. LENGTH OF STAY IN 1b 1 yr. 2 mos.				d. STREET ADDRESS 27 N. Lee St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 N. Lee St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OLLIE Middle E. Last SECRIST				4. DATE OF DEATH Month June Day 12 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1871	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) W. Virginia.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Snowden Feaster				14. MOTHER'S MAIDEN NAME Maggie Rexrode			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT I.R. Likens, 27 N. Lee St. Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6-12- 19 56 , to 6-12-56 , 19____, that I last saw the deceased alive on 6-12-56 , 19____, and that death occurred at 8:55 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. Cumberland, Md. DATE SIGNED 6-12-56							
ACTUAL SIGNATURE Ralph W. Ballin				PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 14, 1956		22c. NAME OF CEMETERY OR CREMATORY McDonald Cemetery		22d. LOCATION (City, town, or county) (State) Maysville, W. Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE 6-14-56		24b. REGISTRAR'S SIGNATURE W R Frantz MD	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				05703	
Within corporate limits 5694				Reg. Dist. No. 4	
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
a. COUNTY ALLEGANY MARYLAND			a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		
c. LENGTH OF STAY IN 1b 1 DAY					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			d. STREET ADDRESS 217 GLENN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROY Middle Christopher Last SHAFER			4. DATE OF DEATH Month JUNE 6 Day Year 1956		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 DECEMBER 23 1903	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Whse. Employee		10b. KIND OF BUSINESS OR INDUSTRY Furniture Co.	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA, Coketon		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ELIJAH SHAFER			14. MOTHER'S MAIDEN NAME ANNA SMITH		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 219-14-6835		
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Chronic Glomerular Nephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 3 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-21-56, 1956, to 6-6-56, 1956, that I last saw the deceased alive on 6-6-56, 1956, and that death occurred at 3:40 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE William P. James M.D.			ADDRESS (Street, city or town, state) 441 N. Center St Cumberland, Md.		
PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES			DATE SIGNED 6-9-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/56	22c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery		22d. LOCATION (City, town, or county) (State) Terra Alta, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland			24a. REC'D BY REGISTRAR DATE 6-9-56		24b. REGISTRAR'S SIGNATURE W.R. Trant, MD

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05704

5725 CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Midland</u>				TOWN <u>Midland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dans Rock Road</u>				STREET ADDRESS (If rural give location) <u>Dans Rock Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>George</u> (Middle) (Last) <u>Shearer</u>				6/30/1956 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>April. 24th. 1889</u>	<u>67</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Miner</u>		<u>Coal Mine</u>		<u>Midland, MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>David Shearer</u>				<u>Rose Ann Robertson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes, World War # 1</u>		<u>214-01-6237</u>		<u>Mrs. Jean Shearer, (WIFE)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
002X IMMEDIATE CAUSE (A)				<u>Midland, MD.</u>		<u>3 months</u>	
ANTECEDENT CAUSE(S) DUE TO				<u>Cachexia + Toxemia</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)				<u>Pulmonary tuberculosis</u>		<u>± 7 mos</u>	
DUE TO (C)				<u>far advanced.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Perforated the intest. ulcers</u>		<u>± 3 mos.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 3, 1955</u> , to <u>June 30, 1956</u> , that I last saw the deceased alive on <u>June 23, 1956</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Frank T. Harvat</u> M.D.		<u>26 Mechanic St. Frostburg</u>		<u>6/30/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/2/1956</u>		<u>Memorial Park</u>		<u>Frostburg, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>7/3/56</u>		<u>Jannette M. Boal</u>		<u>GEORGE EICHHORN, LONACONING, MD</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		35		Jan 1, 1920	
Place of Birth		Cause of Death		Date of Death		Time of Death	
New York City		Heart Disease		Jan 15, 1955		10:00 AM	
Occupation		Signature of Physician		Signature of Registrar		Signature of Witness	
Teacher		[Signature]		[Signature]		[Signature]	
Manner of Death		Certified by		Date		Place	
Natural		[Signature]		Jan 15, 1955		Baltimore, MD	

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland.

2. The cause of death should be stated in as much detail as possible, and should be based on the findings of the physician or other qualified person who has attended the deceased during his last illness. It should not be based on hearsay or rumor.

3. The manner of death should be stated as either "Natural," "Accidental," or "Suicidal." It should be based on the findings of the physician or other qualified person who has attended the deceased during his last illness.

4. The date and time of death should be stated as accurately as possible. It should be based on the findings of the physician or other qualified person who has attended the deceased during his last illness.

5. The place of death should be stated as either "Home," "Hospital," "Nursing Home," or "Other." It should be based on the findings of the physician or other qualified person who has attended the deceased during his last illness.

6. The occupation of the deceased should be stated as accurately as possible. It should be based on the findings of the physician or other qualified person who has attended the deceased during his last illness.

7. The signature of the physician or other qualified person who has attended the deceased during his last illness is required. It should be written in ink and should be legible.

8. The signature of the registrar is required. It should be written in ink and should be legible.

9. The signature of a witness is required. It should be written in ink and should be legible.

10. This certificate is to be filed with the Registrar of the State of Maryland. It is a legal document and its contents are subject to the laws of the State of Maryland.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5695
CERTIFICATE OF DEATH

05705

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 339 City View Terrace		d. STREET ADDRESS 339 City View Terrace	
3. NAME OF DECEASED (Type or print) First Isabella Middle Marie Last Shipper		4. DATE OF DEATH Month June Day 24 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-9-1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Duckworth		14. MOTHER'S MAIDEN NAME Esther Travis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Wm. T. Shipper		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary infarction 4/20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET OF DEATH 2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from May 7 , 19 56 , to June 24 , 19 56 , that I last saw the deceased alive on May 13 , 19 56 , and that death occurred at 1:30 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE R. W. Trevaskis, Jr		M.D. Cumberland, Maryland DATE SIGNED 6/25/56	
PHYSICIAN'S NAME (Type) R. W. Trevaskis, Sr		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-26-1956	22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR June 25, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

TO HOSPITAL OR AT THE DEATH PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5726 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05706

Reg. Dist. No. **6**

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural) Westernport</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stoney Run Road</u>				d. STREET ADDRESS <u>Stoney Run Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DeLores</u> Middle <u>Jean</u> Last <u>Shugars</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>19 56</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 17-1955</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Keyser, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Shugars</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Bowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>(Father) George Shugars, Westernport, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>085.1 Bronchial pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Measles</u> (c) <u> </u> <u> </u> stating the underlying cause lost.</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>about 5 days</u> <u>about 5 days</u></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u></p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 4-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 5, 56</u>		<u>Cabin Run</u>		<u>Mineral Ct. W. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. P. Beal</u>				ADDRESS <u>Westernport</u>		24a. REC'D BY REGISTRAR DATE <u>6-5-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Don C. Kelly</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05707

5696

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 231 Averitt Ave.		d. STREET ADDRESS 700 Lafayette Ave	
3. NAME OF DECEASED (Type or print) First Gilbert Middle Eugene Last Stallings		4. DATE OF DEATH Month June Day 1 Year 19 56	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1-1955
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 1 Yrs. 7 Months 7 Days 7 Hours 7 Min.	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Gilbert LeRoy Stallings		14. MOTHER'S MAIDEN NAME Joan Kathryn Robinette	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT (mother) Mrs. G.L. Stallings, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 921.0 DUE TO Aspiration of stomach contents. Conditions, if any, which gave rise to immediate cause (b) <input type="checkbox"/> (a), stating the underlying cause lost. DUE TO (c) <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2 - 12 June 1 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland, Allegany Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 1-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 4, 1953		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		24. REC'D BY REGISTRAR 6/1/56	
ADDRESS Cumberland Md		24b. REGISTRAR'S SIGNATURE Walter R. Mertz Md	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEST MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Zihlman				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First ANNIE Middle MAY Last STEVENS				4. DATE OF DEATH Month June Day 28 Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-1879		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Benjamin Williams				14. MOTHER'S MAIDEN NAME Sarah Streets			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Geo. H. Stevens, Zihlman, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY HEART DISEASE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month May Day 19 Year 56 Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MAY 19 55 , to 6/28 19 56 , that I last saw the deceased alive on 6/28 19 56 , and that death occurred at 2:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 BROADWAY - FROSTBURG - MD DATE SIGNED 6/29/56							
ACTUAL SIGNATURE MARTIN M. ROTHSTEIN M.D.				PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-1956		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 7-1-56	
				24b. REGISTRAR'S SIGNATURE Mrs. Saucy H. Roe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES H. HARRIS		Male		45		1910		Maryland		Baltimore		Maryland		United States	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH	
Carpenter		Heart Disease		Natural		Several Weeks		April 15, 1956		10:30 AM		Home		Baltimore	
EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH	
High School		Roman Catholic		Married		None		April 15, 1956		10:30 AM		Home		Baltimore	
FATHER'S NAME		MOTHER'S NAME		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
John H. Harris		Mary E. Harris		1885		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
Carpenter		Homemaker		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S EDUCATION		MOTHER'S EDUCATION		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
High School		High School		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S RELIGION		MOTHER'S RELIGION		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
Roman Catholic		Roman Catholic		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S MARRIAGE		MOTHER'S MARRIAGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
Married		Married		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S DEATH		MOTHER'S DEATH		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
1945		1940		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
Heart Disease		Heart Disease		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
Natural		Natural		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S PERIOD OF ILLNESS		MOTHER'S PERIOD OF ILLNESS		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
Several Weeks		Several Weeks		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
April 15, 1956		April 15, 1956		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S TIME OF DEATH		MOTHER'S TIME OF DEATH		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
10:30 AM		10:30 AM		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
Home		Home		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S CITY OF DEATH		MOTHER'S CITY OF DEATH		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
Baltimore		Baltimore		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S STATE OF DEATH		MOTHER'S STATE OF DEATH		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
Maryland		Maryland		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	
FATHER'S COUNTRY OF DEATH		MOTHER'S COUNTRY OF DEATH		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH	
United States		United States		1890		Maryland		Baltimore		Maryland		United States		April 15, 1956	

BUREAU V. 1

5 1956

RECEIVED

5713

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NELLIE MAY STEWART				4. DATE OF DEATH Month June Day 20 Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-1882	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Myers				14. MOTHER'S MAIDEN NAME Sarah Dudley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Chester Stewart,		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Pyloric End. of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 3 mo
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. j. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1956 to June 20, 1956 that I last saw the deceased alive on June 20, 1956 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE WOMC Lane		M.D. 167 E. Main		ADDRESS (Street, city or town, state) Frostburg, Md.		DATE SIGNED June 22, 1956	
PHYSICIAN'S NAME (Type) WOMC Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-23-1956		22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 6-23-56	
				24b. REGISTRAR'S SIGNATURE Wm. Stanley H. Roe			

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 29 1956

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05710

5687

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 HRS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS CREEK ROAD - Rt. 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle EARL Last STRONG		4. DATE OF DEATH Month JUNE Day 9 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-31-1891
9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Farmer Self Employed		10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MARYLAND	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOSEPH STRONG		14. MOTHER'S MAIDEN NAME WILDA ROSS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs Ethelwyn Strong, Cumberland, Md.		Address Rt. 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 33/X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO 33/X (c) Not advanced Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3:30 19 56 to 6-9 19 56 that I last saw the deceased alive on 6-9 19 56 , and that death occurred at 10:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. F. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 6-11-56	
PHYSICIAN'S NAME (Type) W. F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/12/56	22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery Allegany County - Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer - Cumberland, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE 6-12-56		24b. REGISTRAR'S SIGNATURE W. R. Frantz MD	

CERTIFICATE OF DEATH

PLACE OF BIRTH NEW YORK		DATE OF BIRTH 1901	
SEX MALE		RACE WHITE	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
PLACE OF DEATH NEW YORK		DATE OF DEATH 1956	
NAME OF DECEASED JOHN J. ROSS		NAME OF NEXT OF KIN MARY ROSS	
ADDRESS OF DECEASED 1234 5TH AVE. NEW YORK, N.Y.		ADDRESS OF NEXT OF KIN 1234 5TH AVE. NEW YORK, N.Y.	
SIGNATURE OF DECEASED (Blank)		SIGNATURE OF NEXT OF KIN (Blank)	
SIGNATURE OF PHYSICIAN (Blank)		SIGNATURE OF MINISTER OF RELIGION (Blank)	
SIGNATURE OF CORONER (Blank)		SIGNATURE OF JURY (Blank)	
SIGNATURE OF REGISTRAR (Blank)		SIGNATURE OF CLERK (Blank)	

BUREAU A. 2

JUN 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requestor may be retained by hospital or attending physician.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5698

DR. W. F. WILLIAMS

CERTIFICATE OF DEATH

05711

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE		MARYLAND		b. COUNTY		ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CUMBERLAND		c. LENGTH OF STAY IN 1b		94 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		near CUMBERLAND, rural					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		MEMORIAL HOSPITAL		d. STREET ADDRESS		RT. #4, UHL HIGHWAY		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
STELLA		M.		TASCHENBERG				JUNE		22		19		56	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		OCTOBER 21, 1884		71		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
HOUSEWIFE		Own Home		MARYLAND		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
GEORGE W. VALENTINE		MARY WOLFE													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
No		None		MEMORIAL HOSPITAL - CUMBERLAND, MD.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		159X		DUE TO		Carcinomatosis of abdominal viscera. Primary lesion sigmoid.		INTERVAL BETWEEN ONSET AND DEATH		Short time before death.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
Hour a. m. p. m.		While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>													
21. I certify that I attended the deceased from Nov. 21, 1956, to June 22, 1956, that I last saw the deceased alive on June 21, 1956, and that death occurred at 3:00 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED											
ACTUAL SIGNATURE		W. F. Williams		M.D. Cumberland Md		6-22-56									
PHYSICIAN'S NAME (Type)		DR. W. F. WILLIAMS													
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)							
Burial		6/25/56		Rose Hill Cemetery		Cumberland		Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		23a. REC'D BY REGISTRAR		23b. REGISTRAR'S SIGNATURE									
Louis Stein, Inc.		Cumberland, Md.		June 25, 1956		W. L. Hunt, M.D.									

CERTIFICATE OF DEATH

DR. W. F. WILLIAMS

ALLEGANY

10 DAYS

CRINAL HOSPITAL

M. TROCHERUS

2111

OCTOBER 31, 1956

WHITE

MALE

MARY WOLFE

WILLIAM W. WOLFE

CRINAL HOSPITAL - CRINAL, MD.

BUREAU V. 2

JUN 26 1956

RECEIVED

DR. W. F. WILLIAMS

CRINAL HOSPITAL

CRINAL

CRINAL, MD.

CRINAL, MD.

1. With the corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05712

5699 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>3mo. 5days</u>		TOWN <u>Frostburg, Md.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>				STREET ADDRESS (If rural give location) <u>Route # 2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Elizabeth</u> (Middle) <u>Tippen</u> (Last) <u>Tippen</u>				June 21 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	white	widow	11 - 22-1887	68 XXXX yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
housewife		own home		Pa.		U.S.	
13. FATHER'S NAME <u>Thomas Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Plummer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		<u>Mrs. Ralph Herring, Zihlman, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
334X IMMEDIATE CAUSE (A) <u>Coronary sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral arteriosclerosis</u>				?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Schizophrenia Paranoid Type</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 16, 19 56</u> to <u>June 21, 19 56</u> , that I last saw the deceased alive on <u>June 20, 19 56</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James B. Zihlman M.D.</u>		ADDRESS (Street, city, town, state) <u>49 Greene St.</u>		DATE SIGNED <u>6-21-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-23-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Cem Frostburg Md</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>June 23, 1956</u>		REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>734 Montebello</u>		ADDRESS <u>HAFFER FUNERAL HOME 123 E. MAIN, FROSTBURG</u>	

CHANG, R. H.

BUREAU V.

25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053

RECEIVED

5714

CERTIFICATE OF DEATH

05713

Reg. Dist. No.

6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 125 McKinly St.		d. STREET ADDRESS 125 McKinly	
3. NAME OF DECEASED (Type or print) Bertha First Melessia Middle Uhl Last		4. DATE OF DEATH June Month 13 Day 1956 Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months 1 Days 10 IF UNDER 24 HRS. Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Jefferson Clark		14. MOTHER'S MAIDEN NAME Nenneitta Michael	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Walter Uhl Address Westernport			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis and Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 Hour 10 Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 10, 1946 to June 13, 1956 , that I last saw the deceased alive on June 4, 1956 , and that death occurred at 4:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul B. Wilson M.D.		ADDRESS (Street, city or town, state) Piedmont, W. Va. DATE SIGNED JUNE 15, 1956	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	June 16, 1956	Philos	Westernport, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE E. S. Boral ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 6-16-56	24b. REGISTRAR'S SIGNATURE Jane C Kelly

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

JUN 19 1956

RECEIVED

DR. WEISMAN

5700

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 15 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LESTER Middle W. Last WAGNER				4. DATE OF DEATH Month JUNE Day 27 Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 22, 1893	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher - City Street Department				10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME GEORGE WAGNER				14. MOTHER'S MAIDEN NAME ELLEN HOUSE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-669		17. INFORMANT Address MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVES.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction DUE TO 15 days (c) Coronary Sclerosis unknown							INTERVAL BETWEEN ONSET AND DEATH 15 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Arterio Sclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/12, 1956 , to 6/27, 1956 , that I last saw the deceased alive on 6/27, 1956 , and that death occurred at 2:58 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. S. G. Weisman				ADDRESS (Street, city or town, state) 59 Greene St DATE SIGNED 6/28/56			
PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN				Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30, 1956		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Romney, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland				24a. REC'D BY REGISTRAR June 29, 1956		24b. REGISTRAR'S SIGNATURE Walter R. Hantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

JUL 2 1956

RECEIVED

Medical Examiner's Certificate of Death

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Louis</u> Last <u>Warnick</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23-1897</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Coal miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>	
11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Warnick</u>		14. MOTHER'S MAIDEN NAME <u>Rhodda Groves</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-10-2192</u>	
17. INFORMANT <u>Sacred Heart Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma (massive) left side, several yrs</u> DUE TO (b) <u>Metastasis to pericardium with pericardial effusion</u> DUE TO (c) <u>Hydrothorax also ascities.</u> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 5-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/7/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Moscow, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, MD.</u>		24a. REC'D BY REGISTRAR <u>6-7-56</u>	
24b. REGISTRAR'S SIGNATURE <u>MR Drantz, MD</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF TEXAS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes fields for name, age, sex, race, date of death, and place of death. There are also checkboxes for various medical conditions and a section for the examiner's signature and seal.

BUREAU V. 2

IN 11 1956

RECEIVED

CLARENCE JAMES WILLIAMS

CLARENCE JAMES WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5715

CERTIFICATE OF DEATH

Reg. Dist. No.

05716

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 265 E. Main St.			
3. NAME OF DECEASED (Type or print) First HUGH Middle C. Last WATSON				4. DATE OF DEATH Month June Day 16 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-1886		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pay clerk-Retired Coal mines				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Watson				14. MOTHER'S MAIDEN NAME Sarah Close			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1 213-09-6597		17. INFORMANT Mrs. Clara Watson/ Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute circulatory failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH sudden 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from June 12, 1956 , to June 16, 1956 , that I last saw the deceased alive on June 16, 1956 , and that death occurred at 8:59 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frostburg DATE SIGNED June 16, 1956							
ACTUAL SIGNATURE WOM Lane M.D. Frostburg				PHYSICIAN'S NAME (Type) WOM Lane			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-1956		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR DATE 6-18-56		24b. REGISTRAR'S SIGNATURE Wm. Stanley N. Roe	

CERTIFICATE OF DEATH

4715

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1921		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1948		MOBILE		ALABAMA		UNITED STATES		UNITED STATES		JUNE 23, 1968		MOBILE		ALABAMA	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		STATE OF OCCUPATION		COUNTRY OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
FARMER		1948		MOBILE		ALABAMA		UNITED STATES		UNITED STATES		JUNE 23, 1968		MOBILE		ALABAMA	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		CITY OF CAUSE OF DEATH		STATE OF CAUSE OF DEATH		COUNTRY OF CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		1968		MOBILE		ALABAMA		UNITED STATES		UNITED STATES		JUNE 23, 1968		MOBILE		ALABAMA	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		CITY OF MANNER OF DEATH		STATE OF MANNER OF DEATH		COUNTRY OF MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
NATURAL		1968		MOBILE		ALABAMA		UNITED STATES		UNITED STATES		JUNE 23, 1968		MOBILE		ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JUNE 23, 1968		MOBILE		ALABAMA		UNITED STATES		UNITED STATES		JUNE 23, 1968		MOBILE		ALABAMA		UNITED STATES	

BUREAU V. 8

JUN 25 1968

RECEIVED

Reg. Dist. No.

b. COUNTY ALLEGANY

CUMBERLAND

ON A FARM?
YES ☐ NO ☐

Yes

19

IF UNDER 24 HRS

U. S. A.

BESSIE MAE TAYLOR

MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.

INTERVAL BETWEEN
ONSET AND DEATH

Maternal Instinct

19. WAS AUTOPSY

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

YES ☐ NO ☐

(State)

21. I **certify** that I attended the deceased from JUNE 8 9, 1956, to JUNE 8 9, 1956, that I last saw the deceased alive on JUNE 8 9, 1956, and that death occurred at 3:42PM, from the causes and on the date stated above.

DATE SIGNED _____

DR. ROYCE HODGES

(Stote)

24b. REGISTRAR'S SIGNATURE

W. R. F. Smith, M.D.

2060385XV0

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or ~~separation~~, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DEATH CERTIFICATE

DATE OF DEATH

JUNE 12, 1956

PLACE OF DEATH

JUNE 12, 1956

PLACE OF DEATH

SEX

AGE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

1

BUREAU OF VITAL STATISTICS

1956

RECEIVED

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5703

CERTIFICATE OF DEATH

05718

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 days, 10hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS SPRING GAP (NEAR CUMBERLAND)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JOHN DAVIS WHEELER				4. DATE OF DEATH Month Day Year 6 27 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 22-83	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Operating Engineer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM WHEELER				14. MOTHER'S MAIDEN NAME Deliah Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214 05 8544		17. INFORMANT CHART Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident DUE TO (b) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 4 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5-13 , 19 54 , to 6-27 , 19 56 , that I last saw the deceased alive on 6-27-56 , 19 56 , and that death occurred at 5:55 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph W. Ballin				ADDRESS (Street, city or town, state) 62 GREEN ST. CUMBERLAND, MD.			
PHYSICIAN'S NAME (Type) RALPH W. BALLIN, M.D.				DATE SIGNED 6-29-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/56		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.				ADDRESS FREDERICK ST, CUMBERLAND		24a. REC'D BY REGISTRAR June 29, 1956	
				24b. REGISTRAR'S SIGNATURE W.H. Krantz, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

STATE OF TEXAS DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS

1956

Name of Person		Sex		Age		Date of Birth		Place of Birth		Maiden Name		Married Name		Occupation		Education		Religion		Race		Color		Height		Weight		Build		Complexion		Eyes		Hair		Teeth		Fingers		Toes		Scars		Tattoos		Moles		Birthmarks		Other	
John David		Male		25		1931		Texas		John David		John David		Teacher		High School		Methodist		White		White		5'10"		175		Medium		Fair		Blue		Brown		Straight		Straight		Straight		Straight		Straight		Straight		Straight			
John David		Male		25		1931		Texas		John David		John David		Teacher		High School		Methodist		White		White		5'10"		175		Medium		Fair		Blue		Brown		Straight		Straight		Straight		Straight		Straight		Straight		Straight			

BUREAU V. 1

JUL 2 1956

RECEIVED

5716

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NORA</u> <u>FOLEY</u> <u>WILHELM</u>		4. DATE OF DEATH Month Day Year <u>June</u> <u>21</u> , <u>19</u> <u>56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 23, 1886</u>
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Foley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Grimes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James Wilhelm, Frostburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>5</u> , 19 <u>56</u> , to <u>6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/20</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John C. Devens</u> M.D. <u>Frostburg Md 6/22</u> PHYSICIAN'S NAME (Type) <u>John C Devens</u> <u>Frostburg Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-23-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst, Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-23-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy N. Roe</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED ALAN RAY		2. SEX MALE		3. AGE 35		4. DATE OF DEATH JUN 29 1966	
5. PLACE OF DEATH AT HOME		6. CAUSE OF DEATH HEART DISEASE		7. MANNER OF DEATH NATURAL		8. SIGNATURE OF PHYSICIAN [Signature]	
9. SIGNATURE OF DECEASED [Signature]		10. SIGNATURE OF WITNESS [Signature]		11. SIGNATURE OF DECEASED [Signature]		12. SIGNATURE OF WITNESS [Signature]	
13. SIGNATURE OF DECEASED [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF DECEASED [Signature]		16. SIGNATURE OF WITNESS [Signature]	
17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF WITNESS [Signature]		19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF WITNESS [Signature]	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF WITNESS [Signature]	
25. SIGNATURE OF DECEASED [Signature]		26. SIGNATURE OF WITNESS [Signature]		27. SIGNATURE OF DECEASED [Signature]		28. SIGNATURE OF WITNESS [Signature]	
29. SIGNATURE OF DECEASED [Signature]		30. SIGNATURE OF WITNESS [Signature]		31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF WITNESS [Signature]	
33. SIGNATURE OF DECEASED [Signature]		34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF DECEASED [Signature]		36. SIGNATURE OF WITNESS [Signature]	
37. SIGNATURE OF DECEASED [Signature]		38. SIGNATURE OF WITNESS [Signature]		39. SIGNATURE OF DECEASED [Signature]		40. SIGNATURE OF WITNESS [Signature]	
41. SIGNATURE OF DECEASED [Signature]		42. SIGNATURE OF WITNESS [Signature]		43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF WITNESS [Signature]	
45. SIGNATURE OF DECEASED [Signature]		46. SIGNATURE OF WITNESS [Signature]		47. SIGNATURE OF DECEASED [Signature]		48. SIGNATURE OF WITNESS [Signature]	
49. SIGNATURE OF DECEASED [Signature]		50. SIGNATURE OF WITNESS [Signature]		51. SIGNATURE OF DECEASED [Signature]		52. SIGNATURE OF WITNESS [Signature]	
53. SIGNATURE OF DECEASED [Signature]		54. SIGNATURE OF WITNESS [Signature]		55. SIGNATURE OF DECEASED [Signature]		56. SIGNATURE OF WITNESS [Signature]	
57. SIGNATURE OF DECEASED [Signature]		58. SIGNATURE OF WITNESS [Signature]		59. SIGNATURE OF DECEASED [Signature]		60. SIGNATURE OF WITNESS [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF WITNESS [Signature]		63. SIGNATURE OF DECEASED [Signature]		64. SIGNATURE OF WITNESS [Signature]	
65. SIGNATURE OF DECEASED [Signature]		66. SIGNATURE OF WITNESS [Signature]		67. SIGNATURE OF DECEASED [Signature]		68. SIGNATURE OF WITNESS [Signature]	
69. SIGNATURE OF DECEASED [Signature]		70. SIGNATURE OF WITNESS [Signature]		71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF WITNESS [Signature]	
73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF WITNESS [Signature]		75. SIGNATURE OF DECEASED [Signature]		76. SIGNATURE OF WITNESS [Signature]	
77. SIGNATURE OF DECEASED [Signature]		78. SIGNATURE OF WITNESS [Signature]		79. SIGNATURE OF DECEASED [Signature]		80. SIGNATURE OF WITNESS [Signature]	
81. SIGNATURE OF DECEASED [Signature]		82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF WITNESS [Signature]	
85. SIGNATURE OF DECEASED [Signature]		86. SIGNATURE OF WITNESS [Signature]		87. SIGNATURE OF DECEASED [Signature]		88. SIGNATURE OF WITNESS [Signature]	
89. SIGNATURE OF DECEASED [Signature]		90. SIGNATURE OF WITNESS [Signature]		91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF WITNESS [Signature]	
93. SIGNATURE OF DECEASED [Signature]		94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF DECEASED [Signature]		96. SIGNATURE OF WITNESS [Signature]	
97. SIGNATURE OF DECEASED [Signature]		98. SIGNATURE OF WITNESS [Signature]		99. SIGNATURE OF DECEASED [Signature]		100. SIGNATURE OF WITNESS [Signature]	

RECEIVED
JUN 29 1966
BUREAU V. 8

5704

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 24 HRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MR. LESTER S. WILLIAMS				4. DATE OF DEATH Month JUNE Day 14 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 20, 1884	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio Entertainer (Retired)				10b. KIND OF BUSINESS OR INDUSTRY HYNDMAN, PA.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME GEORGE WILLIAMS				14. MOTHER'S MAIDEN NAME Agnes Bonnell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL, CUMBERLAND, MD.			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage with rt. Hemiplegia 5 days DUE TO (b) Gen. arteriosclerosis DUE TO (c) Hypertensive vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 13 June, 1956 to 14 June, 1956 that I last saw the deceased alive on 14 June, 1956 , and that death occurred at 7:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. A. Van Ormer				ADDRESS (Street, city or town, state) Cumberland, Md.			
DATE SIGNED June 15, 1956				DATE SIGNED June 15, 1956			
PHYSICIAN'S NAME (Type) DR. W.A. VAN ORMER				DATE SIGNED June 15, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/17/56			
22c. NAME OF CEMETERY OR CREMATORY Dawson Cemetery				22d. LOCATION (City, town, or county) (State) Allegany County, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05721			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. X2			
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D.#2 Flintstone</u>					c. LENGTH OF STAY IN 1b <u>43 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural) R.F.D.#2 Flintstone</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Murley Branch Road</u>					d. STREET ADDRESS <u>Murley Branch Road</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>Growden</u> Last <u>Wilson Jr.</u>					4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>19 56</u>								
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30-1912</u>		9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Foreman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>George Const.Co.</u>			11. BIRTHPLACE (State or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Marshall G. Wilson</u>					14. MOTHER'S MAIDEN NAME <u>Susan North</u>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>214-14-7886</u>		17. INFORMANT Address <u>Helen G. Wilson, R.F.D.#2 Flintstone</u> <u>Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation and Intra-abdominal hemorrhage</u> DUE TO (b) <u>due to a crushed pelvis.</u> DUE TO (c) <u>Tractor rolled over on him.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>rolled over sideways on him.</u> <u>Mowing grass with aid of tractor on side hill, tractor</u>												INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>rolled over sideways on him.</u>									
20c. TIME OF INJURY Month, Day, Year Hour <u>6:10</u> P. M. <u>6:12</u> 19 <u>56</u>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm at home</u>		20f. (City or town) <u>Rural) Flintstone, Allegany</u>		(County) <u> </u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 13-1956</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>6/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Meadow</u>			22d. LOCATION (City, town, or county) (State) <u>Near Flintstone, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>					ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>6-15-56</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frazier M.D.</u>				

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU A. 3

JUN 18 1955

RECEIVED

5705

CERTIFICATE OF DEATH

Reg. Dist. No.

DR. HIMMELWRIGHT

1. PLACE OF DEATH a. COUNTY CUMBERLAND, ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near CUMBERLAND, Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMMA Middle F. Last WOLFE				4. DATE OF DEATH Month 6 Day 17 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25 1868	
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE CLAUSON				14. MOTHER'S MAIDEN NAME SHAFER, LE ANNA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO Advanced Age (c) Advanced Age							INTERVAL BETWEEN ONSET AND DEATH 3 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 1954 to June 1956 , that I last saw the deceased alive on June 17, 1956 , and that death occurred at 6:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 133 Virginia Ave, Cumberland, Md DATE SIGNED 6/17/56							
ACTUAL SIGNATURE Dr. Himmelwright M.D.				PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein				ADDRESS Cumberland, Md		24a. REC'D BY REGISTRAR June 19, 1956	
				24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

JUN 21 1956

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VS. A1SME(5)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5706 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)	
Allegany		a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cumberland		Ellerslie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last George M. Wolfe		Month Day Year June 20 19 56	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Male	white		March 27-1927
9. AGE (in years last birthday)	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY
29 yrs.	Electrician - Sargent		Electric Co.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ellerslie		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Oscar Wolfe		Della Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
Yes <input checked="" type="checkbox"/> after W.W.2		213-22-4125	
17. INFORMANT		Address	
Memorial Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock also 1st, 2nd. & 3rd. burns of body 916.3			
DUE TO (b) except feet, abdomen & lower part of back.			
DUE TO (c) Explosion & flash fire			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		?-Presume, accumulation of gas, explosion & flash fire.	
20c. TIME OF INJURY Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, dept. office bldg., etc.)	20f. (City or town) (County) (State)
7:30 a.m. 6-19 19 56	While / at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	Pittsburg P. Glass	North Branch Allegany Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 20-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	June 23, 1956	Hillcrest Burial Park	Cumberland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Harvey H. Zeigler, Hyndman, Pennsylvania.		June 21, 1956	W.R. Frantz M.D.

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